ONONDAGA PHYSICAL THERAPY
helping you live, work and play better

Registration Form
(Please Print Clearly)

PATIENT INFORMATION

TODAY'S DATE: / / PRIMARY CARE PHYSICIAN:

Patient's Last Name	First	Middle	What would you prefer to be called?

Street Address	City	State	Zip Code

Home Phone	Work Phone (extension)	Cell Phone	Sex	Age	Date of Birth
			□ Male □ Female		/ /

Email Address:	How would you like us to keep in touch with you?
	□ Email □ Postal Mail

Marital Status	Employment Status	Accident?	Date Of Next Physician Appt
□ Single □ Married □ Widowed □ Divorced	□ Full □ Part □ Retired □ Not Employed □ Other	□ None □ Auto □ Work □ Other	/ /

INSURANCE INFORMATION (Please Show Your Insurance Cards)

Primary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #

Patient Relationship To Policy Holder: □ Self □ Spouse □ Child □ Other_____

Secondary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #

Patient Relationship To Policy Holder: □ Self □ Spouse □ Child □ Other_____

IN CASE OF EMERGENCY

Contact Name	Relationship To Patient	Home Phone	Cell Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Onondaga Physical Therapy, LLC. I understand that I am financially responsible for any balance that is unpaid by my insurance company. I understand Onondaga Physical Therapy will impose a late fee of $25 for any balance that is older than 90 days, unless I have prior payment arrangements. I further authorize Onondaga Physical Therapy, LLC and my insurance company to release any information that is required to process my claims.

I hereby consent to treatment procedures and patient care which in the judgment of my therapist and/or physician may be considered necessary or advisable while I am a patient of Onondaga Physical Therapy, LLC.

I hereby authorize the use or disclosure of my individually identifiable health information as described in the NOTICE OF PRIVACY PRACTICES I received.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

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Medical History Form

(Please Print Clearly)

Name:	Date:

Have you EVER been diagnosed as having any of the following conditions?

Yes No Heart Problems	Yes No Epilepsy / Seizures	Yes No Implanted Devices
Yes No High Blood Pressure	Yes No Hearing Loss / Disorder	Yes No Cancer
Yes No Pacemaker	Yes No Eye Disease	Yes No Osteoporosis
Yes No Rheumatoid Arthritis	Yes No Muscular Disease / Disorder	Yes No Depression
Yes No Other Arthritic Condition	Yes No Multiple Sclerosis	Yes No Past Pregnancy
Yes No Stroke	Yes No Tuberculosis	Yes No Currently pregnant
Yes No Lung Disease	Yes No Circulation Problems	Yes No Chemical Dependency
Yes No Asthma	Yes No Hepatitis	Yes No Other:
Yes No Diabetes	Yes No Kidney Disease	

Please list any surgeries or other medical conditions for which you have been treated

Date	Surgery/Injury/Condition	Reason:

List all medications you are currently taking (pills, injections, inhalers, skin patches):

Any additional comments or information you would like us to know:

X _____

PATIENT/GUARDIAN SIGNATURE DATE

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HIPAA Privacy Information

TODAY'S DATE: / /

PATIENT INFORMATION

Patient's Last Name First Name Date of Birth

CONTACT METHODS

Please check the appropriate boxes indicating acceptable ways for us to contact you regarding either your appointment(s) or other medical information. By checking these boxes, you give us permission to contact you and/or leave messages.

Appointment Information	Medical Information
□ Home Phone	□ Home Phone
□ Mobile Phone	□ Mobile Phone
□ Mobile Text**	□ Mobile Text**
□ Work Phone	□ Work Phone
□ With another person:	□ With another person:
□ Send Via Mail	□ Send Via Mail
□ Send Via Email	□ Send Via Email

**Checking the Mobile Phone box will enroll you in Text Message Appointment Reminders. Messages are an automated reminder only and are delivered the night before your appointments with us. Carrier messaging rates apply per your plan.

If you have authorized us to communicate medical or appointment information with another individual, please provide their name and relationship:

Name: _____ Relationship: _____

AGREEMENT INFORMATION

I have read the above information and have authorized Onondaga Physical Therapy to relay appointment or medical information in the manners I have specified above.

x _____

PATIENT SIGNATURE DATE

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Attendance Policy

Onondaga Physical Therapy requires a minimum 24-hour notice when cancelling any appointment

- Cancellations may be submitted via text message or phone call to (315) 635-5000
- It is expected for you to arrive on time to all scheduled appointments. If you arrive more than **10 minutes late,** you will be considered a "no show".
- Text message reminders are a courtesy and should NOT be used as a primary method of tracking your appointments as they are not 100% reliable.

Please be considerate of our other patients - If your **personal or work** schedule might affect your ability to keep your appointment, please don't schedule until you are certain you can keep your time. We do utilize a waiting list so that we can offer cancelled appointment slots to other patients waiting to be treated.

We are sensitive to the fact that an emergency may occur in a rare instance and do offer 1 cancellation per month as a courtesy for these instances.

Late Cancellation (less than 24 hours notice) and No-Show Fees:

- 1st late cancel/No Show per month - Fee Waived
- 2nd late cancel/No Show per episode of care - $25
- 3rd late cancel/No Show per episode of care - $50
- 4th late cancel/No Show per episode of care - $65

(Exceptions may be made for bad weather when schools in our area close or dismiss early as well as travel advisories issued for Onondaga County.)

If you fail to show for an appointment or cancel without speaking to one of us, we will call or text you to remind you of your next appointment. If we do not hear from you by the next morning confirming this appointment, we will **delete all future appointments** opening up opportunities for us to help other patients. Please call to reschedule your appointments.

I agree to abide by the above policy and to pay the above fee PRIOR to my next appointment if I am in violation. I understand these charges will NOT be covered by my insurance company.

X _____

Printed Name **Signature** **Date**

Therapist Reviewed (Initial): _____

Name & DOB:_____ Date:_____

The Dizziness Handicap Inventory (DHI)

P1. Does looking up increase your problem?	o Yes o Sometimes o No
E2. Because of your problem, do you feel frustrated?	o Yes o Sometimes o No
F3. Because of your problem, do you restrict your travel for business or recreation?	o Yes o Sometimes o No
P4. Does walking down the aisle of a supermarket increase your problems?	o Yes o Sometimes o No
F5. Because of your problem, do you have difficulty getting into or out of bed?	o Yes o Sometimes o No
F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	o Yes o Sometimes o No
F7. Because of your problem, do you have difficulty reading?	o Yes o Sometimes o No
P8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	o Yes o Sometimes o No
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	o Yes o Sometimes o No
E10. Because of your problem have you been embarrassed in front of others?	o Yes o Sometimes o No
P11. Do quick movements of your head increase your problem?	o Yes o Sometimes o No
F12. Because of your problem, do you avoid heights?	o Yes o Sometimes o No
P13. Does turning over in bed increase your problem?	o Yes o Sometimes o No
F14. Because of your problem, is it difficult for you to do strenuous homework or yard work?	o Yes o Sometimes o No
E15. Because of your problem, are you afraid people may think you are intoxicated?	o Yes o Sometimes o No
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	o Yes o Sometimes o No
P17. Does walking down a sidewalk increase your problem?	o Yes o Sometimes o No
E18.Because of your problem, is it difficult for you to concentrate	o Yes o Sometimes o No
F19. Because of your problem, is it difficult for you to walk around your house in the dark?	o Yes o Sometimes o No

E20. Because of your problem, are you afraid to stay home alone?	o Yes o Sometimes o No
E21. Because of your problem, do you feel handicapped?	o Yes o Sometimes o No
E22. Has the problem placed stress on your relationships with members of your family or friends?	o Yes o Sometimes o No
E23. Because of your problem, are you depressed?	o Yes o Sometimes o No
F24. Does your problem interfere with your job or household responsibilities?	o Yes o Sometimes o No
P25. Does bending over increase your problem?	o Yes o Sometimes o No

Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. *Arch Otolaryngol Head Neck Surg* 1990;116: 424-427

DHI Scoring Instructions

The patient is asked to answer each question as it pertains to dizziness or unsteadiness problems, specifically considering their condition during the last month. Questions are designed to incorporate functional (F), physical (P), and emotional (E) impacts on disability.

To each item, the following scores can be assigned:
No=0 Sometimes=2 Yes=4

Scores:
Scores greater than 10 points should be referred to balance specialists for further evaluation.

16-34 Points (mild handicap)
36-52 Points (moderate handicap)
54+ Points (severe handicap)

Score: _____