

ACE PHYSICAL THERAPY & SPORTS MEDICINE INSTITUTE PATIENT REGISTRATION

ALEXANDRIA	ARLIN	IGTON [FAIRFAX	FAI	LS CHUR	ксн 🔲	GREAT FAI	LLS	HERND	ON [LEESE	SURG TYSONS CORNER	
PATIENT INFORMATION (Please Print Clearly)												Date	
Name Last First Middle						D	ate of Birtl	h	Age	Sex M F	Social Security No.		
The state of the s													
Home Address Street City State & Zip Code													
Home Telephone Work Telephone			Occupation				Employee	d By					
Employer's Address Street				C	City				State & Zip Code				
PERSON FIN	ANCIA				/ INSU								
Name Last		First		Middle		Relations	ship to Patien	nt]	Date of E		Social Security No.	
Home Address	,	Street			City			State & Z			ip Code		
Home Telephone		Work Tel	ephone	'	Occupation	n		Employed By					
Employer's Address	S	Street			City					İ	State & Zi	p Code	
HEALTH INS	SURAN	ICE IN	FORMA'	TION									
Primary Insurance Co.		· - ·			Address		Street						
City					State &			Zip Code				Telephone No.	
Policy / ID #		Group #		Name of Policyholder		lder	Date of	Date of Birth of Policyholder			Relationship to Patient		
Secondary Insurance C	Co.	ı			Address		Street					1	
City							State & Zip	Code				Telephone No.	
Policy / ID #		Group #		Name of Policyholder		lder	Relationship to Patient				Is this HMO/PPO? Yes No		
AUTOMOBII	FAC	CIDEN	Т		I			l .				1	
Date of Accident	Time	[] AM	Were you			ou Have	Medical Ben	efits Unde	er Your A	Auto Ins.	? If Ye	s, Policy No. / Claim#	
		[] PM	[] Driver	[] Passenge	ger Yes No								
Your Automobile Insu	irance Carri	ier	Address								Telephone No.		
Your Agent's Name Telephone N			No. Your Claim Ac			Claim Adjust	uster's Name			Telephone No.			
Other Party's Automobile Carrier			Address							Telephone No.			
Other Party's Claim Adjuster's Name			Claim No.						Telephone No.				
COMPLETE IF AN ATTORNEY IS REPRESENTING YOU													
Attorney's Name					<u> LDLI</u>	Telephone No.				Fax No.			
Address													
WORKMAN'S COMPENSATION (Injury on the Job)													
Date of Injury Claim No. Compensation Insurance Co.													
Insurance Company Address													
Contact Person's Name Telephone No.													
Employer at Time of Injury Telephone No.													
Was Injury Reported to	o Superviso	or?		Date Rep	eported Name of Supervis		Supervisor	visor			Telephone No.		
For Office Use Only													
☑						PATIENT'S ACCOUNT NO.							

Nearest Relative/Friend Name	Who should we notify in case of eme Relationship	Home Phone	Work Phone
Living With You:			
Nearest Relative/Friend Name NOT Living With You:	Relationship	Home Phone	Work Phone
	AUTHODIZATIO	NAT.	
_	AUTHORIZATIO hereby authorize ACE PHYSICA		S MEDICINE INSTITUTE to
ply for benefits on my behalf for covered ser	vices rendered by the staff of AC	E PHYSICAL THERAPY	% SPORTS MEDICINE
NSTITUTE. REQUEST THAT PAYMENT FOR THES	SE SERVICES BE PAID BY		
Insurance Company #1	S.S. # of Insured	/ID	Group
nd/or			
Insurance Company #2	S.S. # of Insured /	ID	Group
ministration. I PERMIT A COPY OF THIS A revoked by me at any time in writing. I under yments or reimbursements.			
ITNESS_	SIGNATURE OF PATIENT, SUBSCRIBER	DAT	E
	SIGNATURE OF PATIENT, SUBSCRIBER	, GUARDIAN OR BENEFICIARY	-
	SIGNATURE OF PATIENT, SUBSCRIBER FINANCIAL POLICE	, GUARDIAN OR BENEFICIARY	
syment of the charges for our services is the u	FINANCIAL POLICE ies are described below. Itimate responsibility of the patie	, GUARDIAN OR BENEFICIARY	
ayment of the charges for our services is the usept when alternative arrangements are made LEASE BE AWARE THAT INSURANCE CAY RESULT FROM DEDUCTIBLE OR CONSURANCE COMPANY HAS ADOPTED A COMPANY'S FAILURE TO FULLY COVER	FINANCIAL POLICE ies are described below. Itimate responsibility of the paties in advance with us. OMPANIES OFTEN DO NOT FOPAYMENT PROVISIONS IN A FEE SCHEDULE, OR FOR OT	CIES The Patient's Policy The Patient's Policy The Patient's Policy The REASONS. HOWE	t the time services are rendere ICAL THERAPY BILL. THI Y, OR BECAUSE THE IVER, AN INSURANCE
ayment of the charges for our services is the uscept when alternative arrangements are made LEASE BE AWARE THAT INSURANCE CLAY RESULT FROM DEDUCTIBLE OR CONSURANCE COMPANY HAS ADOPTED A OMPANY'S FAILURE TO FULLY COVER UR BILL IN FULL. Tyou are unable to keep your scheduled appointment time and obtain a cance have the cancellation#, you agree to pay \$75.00	FINANCIAL POLICE ies are described below. Itimate responsibility of the paties in advance with us. OMPANIES OFTEN DO NOT FOPAYMENT PROVISIONS IN A FEE SCHEDULE, OR FOR OT A OUR BILL DOES NOT RELIES INTERIOR OF THE PROVISION OF	CIES THE PATIENT'S POLICE THE REASONS. HOWE VE THE PATIENT OF THE	t the time services are rendered ICAL THERAPY BILL. THI Y, OR BECAUSE THE EVER, AN INSURANCE HE OBLIGATION TO PAY The content of the content
ayment of the charges for our services is the usept when alternative arrangements are made LEASE BE AWARE THAT INSURANCE CAY RESULT FROM DEDUCTIBLE OR CONSURANCE COMPANY HAS ADOPTED A COMPANY'S FAILURE TO FULLY COVER UR BILL IN FULL. you are unable to keep your scheduled appoint heduled appointment time and obtain a cance the cancellation#, you agree to pay \$75.00/ Initials LEASE NOTE: During the course of treatmeetrodes may be necessary. These electrodes	FINANCIAL POLICE ies are described below. Itimate responsibility of the paties in advance with us. OMPANIES OFTEN DO NOT FOUTED PAYMENT PROVISIONS IN A FEE SCHEDULE, OR FOR OT A OUR BILL DOES NOT RELIES IN THE PROVISION IN THE PROVISION IN A FEE SCHEDULE, OR FOR OT A OUR BILL DOES NOT RELIES IN THE PROVISION I	CIES The Payment is expected a control of the Patient's Policy of the Patient's Policy of the Patient of the P	t the time services are rendered ICAL THERAPY BILL. THIY, OR BECAUSE THE EVER, AN INSURANCE HE OBLIGATION TO PAY sents 48 hours before your ar appointment time and do not insurance company.
or the benefit of our patients, our billing polic ayment of the charges for our services is the uscept when alternative arrangements are made LEASE BE AWARE THAT INSURANCE COMPANY RESULT FROM DEDUCTIBLE OR CONSURANCE COMPANY HAS ADOPTED A OMPANY'S FAILURE TO FULLY COVER OUR BILL IN FULL. Syou are unable to keep your scheduled appoint the cancellation#, you agree to pay \$75.00/ Initials LEASE NOTE: During the course of treatment of the course has be necessary. These electrodes for the carchase his/her own electrodes. Sour bill is not paid in full when due, we encoured the carchase his/her own electrodes. Sour bill is not paid in full when due, we encoured the carchase his/her own electrodes. Tour bill is not paid in full when due, we encoured the carchase his/her own electrodes. Tour bill is not paid in full when due, we encoured the carchase his/her own electrodes. Tour bill is not paid in full when due, we encoured the carchase his/her own electrodes. Tour bill is not paid in full when due, we encoured the parties of the par	FINANCIAL POLICE ies are described below. Itimate responsibility of the paties in advance with us. OMPANIES OFTEN DO NOT FOUNDAMENT PROVISIONS IN FEE SCHEDULE, OR FOR OT COUR BILL DOES NOT RELIES. Interest, we request that you call llation#. If you fail to cancel you missed appointment fee. This fee that the patient's skew contact with the patient's skew contact with the patient's skew contact with 190 days will be related of 1.4% WILL ACCRUSS OF 20% ON THE UNPAID B.	CIES THE PATIENT'S POLICE THE REASONS. HOWEVE THE PATIENT OF THE	t the time services are rendered ICAL THERAPY BILL. THE Y, OR BECAUSE THE EVER, AN INSURANCE HE OBLIGATION TO PAY sents 48 hours before your ar appointment time and do not insurance company. Deart of treatment, the use of fety, patients will be required sent arrangements that may be LOWING 90 DAYS AND ALL COLLECTION COSTS WILL BE ADDED T



Consent Agreement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we inform you of our policy regarding the protection of your health information through our Privacy Notice. Please refer to our Privacy Notice, which is available to you along with this consent agreement, for a full explanation of how this office will protect your health information. You may print or view a copy of the notice through our website at: www.ace-pt.org, by clicking on the **Notice of Privacy Practices** link.

Phone:

□ 2841 Hartland Rd, # 401B • Falls Church, VA 22043 • (703) 205-1233
□ 108 Elden Street, #12 • Herndon, VA 20170 • (703) 464-0554
□ 19465 Deerfield Ave, #311 • Leesburg, VA 20176 • (703) 726-9702
□ 12011 Lee Jackson Memorial Hwy, #101 • Fairfax, VA 22030• (703) 273-4616
□ 2877 Duke Street • Alexandria, VA 22314• (703) 212-8221
□ 8230 Boone Blvd, #202 • Vienna, VA 22182• (703) 288-9066
□1701 Clarendon Blvd, #110• Arlington, VA 22209 • (703) 205-1237
□ 10123 Colvin Run Road • Great Falls, VA 22066 • (703) 759-7820



Patient Signature:

Therapist Signature:

PHYSICAL THERAPY VESTIBULAR & BALANCE EVALUATION

INTAKE INFORMATION

	INTAKE	INFORMATION	Date:
			Hand dominance:
			Date of onset:
Return doctor's visit:			Date of surgery:
		ood Pressure	ension □ Diabetes □ High Cholester
•	•		biotic use Osteoporosis Falls
•			olotic use - Osteopolosis - Tulis
= 110uu 11uumu = Mampie S			
Social history: Smoke	Drink: amount/how ofte	n	☐ History of heavy regular drinkin
			ber:
HISTORY OF PRESENT IL	LNESS/SUBJECTIVE		
Chief complaint:			
Setting in which Symptoms f	ïrst occurred:		
Description of Symptoms: \Box	vertigo (sense of spinnin	g) \Box off-balance \Box l	
Description of Symptoms: ☐ Symptoms are getting: ☐ bett	vertigo (sense of spinnin ter □ worse □ same □	ng) □ off-balance □ l □ episodic	
Description of Symptoms: ☐ Symptoms are getting: ☐ bett Description of Spells: ☐ con	vertigo (sense of spinnin ter	ng) □ off-balance □ l □ episodic □ induced by motion □	ightheadedness/faint
Description of Symptoms: Symptoms are getting: bett Description of Spells: con Length of time spells occur:	vertigo (sense of spinnin ter	ng) □ off-balance □ l □ episodic □ induced by motion □ □ hours □ days □ othe	ightheadedness/faint induced by position changes □ other □
Description of Symptoms: Symptoms are getting: better Description of Spells: con Length of time spells occur: What increases symptoms?	vertigo (sense of spinnin ter	ng) □ off-balance □ l □ episodic □ induced by motion □ □ hours □ days □ othe	ightheadedness/faint induced by position changes □ other □
Description of Symptoms: Symptoms are getting: better Description of Spells: con Length of time spells occur: What increases symptoms? What decreases symptoms?	vertigo (sense of spinnin ter worse same stant spontaneous seconds minutes	ng) □ off-balance □ l □ episodic □ induced by motion □ □ hours □ days □ othe	ightheadedness/faint induced by position changes □ other □
Description of Symptoms: Symptoms are getting: bett Description of Spells: con Length of time spells occur: What increases symptoms? What decreases symptoms? Hearing impairments: yes	vertigo (sense of spinnin ter	ng) □ off-balance □ l □ episodic □ induced by motion □ □ hours □ days □ othe	ightheadedness/faint induced by position changes □ other r
Description of Symptoms: Symptoms are getting: bett Description of Spells: con Length of time spells occur: What increases symptoms? What decreases symptoms? Hearing impairments: yes Changes in hearing since ons	vertigo (sense of spinnin ter	ng) □ off-balance □ l □ episodic □ induced by motion □ □ hours □ days □ othe □ plain	ightheadedness/faint induced by position changes □ other r
Description of Symptoms: Symptoms are getting: better Description of Spells: con Length of time spells occur: What increases symptoms? What decreases symptoms? Hearing impairments: yes Changes in hearing since ons Visual changes since onset:	vertigo (sense of spinnin ter worse same stant spontaneous seconds minutes	g)	ightheadedness/faint induced by position changes □ other r
Description of Symptoms: Symptoms are getting: better Description of Spells: con Length of time spells occur: What increases symptoms? What decreases symptoms? Hearing impairments: yes Changes in hearing since onset: Visual changes since onset: Recent falls: yes no	vertigo (sense of spinnin ter worse same stant spontaneous seconds minutes	g)	ightheadedness/faint induced by position changes □ other r
Description of Symptoms: Symptoms are getting: bett Description of Spells: con Length of time spells occur: What increases symptoms? What decreases symptoms? Hearing impairments: yes Changes in hearing since ons Visual changes since onset: Recent falls: yes no History of migraines: yes	vertigo (sense of spinnin ter	g)	ightheadedness/faint induced by position changes □ other r
Description of Symptoms: Symptoms are getting: better Description of Spells: con Length of time spells occur: What increases symptoms? What decreases symptoms? Hearing impairments: yes Changes in hearing since onset: Recent falls: yes no History of migraines: yes Previous treatments:	vertigo (sense of spinnin ter	g) □ off-balance □ l □ episodic □ induced by motion □ □ hours □ days □ othe plain	ightheadedness/faint induced by position changes □ other r

Date: _____

Musculo	skeletal Screen:
=	Cervical: WNL Limited:
•	LE Strength: WNL: Weakness:
Auditory	y Screen: Phy Sports
•	Weber □ Negative □ Lateralizes: Right/ Left
•	Rinne \Box Air Conduction > Bone Conduction \Box Bone Conduction > Air Conduction
Somatos	sensory Testing
= <u>{</u>	Sensation:
	o Left LE : □ WNL/intact □ Diminished □ Absent
	o Right LE : □ WNL/intact □ Diminished □ Absent
•]	Proprioception:
	o Left LE : □ WNL/intact □ Impaired □ Absent
	o Right LE : □ WNL/intact □ Impaired □ Absent
-	Coordination:
	o Rapid Alternating movements
	■ Alternating foot taps: □ WNL □ Dysdiadochokinesia
	■ Heel to shin: □ WNL □ Dysdiadochokinesia
	■ Alternating hand taps: □ WNL □ Dysdiadochokinesia
	■ Alternating supination/pronation: □ WNL □ Dysdiadochokinesia
Postural	Control Tests:
•	Balance (Romberg):
	○ Standing level/ firm surface Eyes Open: ☐ WNL ☐ Sway: Mild/ Moderate/ Severe / LOB
	○ Standing level/ firm surface Eyes Closed: ☐ WNL ☐ Sway: Mild/ Moderate/ Severe / LOB
-	CTSIB:
	○ Standing on foam Eyes Open: □ WNL □ Sway: Mild/ Moderate/ Severe / LOB
	○ Standing on foam Eyes Closed: □ WNL □ Sway: Mild/ Moderate/ Severe / LOB
•	Fukuda Step test
	0 + / -
	o Direction: Right / Left
Gait	
	Standard: WNL Unsteady
	With head vertical movements: □ WNL □ Unsteady
•	With head horizontal rotation: WNL Unsteady

Tandem Gait: \square WNL \square Unsteady

Comments:

Oculomotor Testing:

•	Smooth Pursuits (H-test):
•	Saccades (Nose to finger): WNL Abnormal
•	Head Thrust: ☐ WNL ☐ Positive: Right/ Left / Bilateral Physical Therapy & Sports Medicine Institute
•	Heave Test: ☐ WNL ☐ Positive: Right/ Left / Bilateral
•	Gaze Stability with fixation:
	o □ negative
	\circ \Box 1° \Box 2° \Box 3° Nystagmus: Right / Left
•	Gaze Stability without fixation: (use of infrared goggles)
	o □ negative
	o □1° □ 2° □ 3° Nystagmus: Right / Left
•	Visual Acuity
	o Static: Line #:
	o Dynamic: Line #:
Vestibu	ular Testing
•	<u>Head Shake without fixation</u> (10 sec): \Box negative \Box Nystagmus: Right / Left
•	<u>Hyperventilation without fixation</u> (40 sec): \square negative \square Nystagmus: Right / Left
•	<u>Vibration Induced Nystagmus:</u>
	o Right: □ Nystagmus: Right / Left □ No nystagmus
	o Left: □ Nystagmus: Right / Left □ No nystagmus
•	Valsalva Induced Dizziness:
	○ □ Patient reported: Yes / No □ Nystagmus: + / - Direction:
•	Positional Testing:
	o Dix-Hallpike
	■ Right: ☐ Negative ☐ Nystagmus: Right/ Left Torsional, Up-beating / Down-beating
	Duration of nystagmus:
	• Return to sit
	Associated complaints of dizziness?
	■ Left: ☐ Negative ☐ Nystagmus: Right/ Left Torsional, Up-beating / Down-beating
	Duration of nystagmus:
	• Return to sit
	Associated complaints of dizziness?
	o Roll Test:
	■ Right: □ Negative □Nystagmus: Geotropic / Ageotropic □ Duration
	■ Left: Negative Nystagmus: Geotropic / Ageotropic Duration



Are you currently taking ANY kind of medication(s)?	No Yes If yes, please list below:
(Please list ALL prescription, over-the counter, herbal, and vit	tamin/mineral/dietary (nutritional) supplements)

If you do not remember the dosage and frequency, please indicate with a question (?) mark

Name	Dosage	Frequency	Route of Admir	nistration (Check	as applicable)
			Oral	Injection	Topical

To the best of my knowledge/ability, I have listed all current medi	ications, its dosage, frequency and route of administration
Patient Signature: 🗹	Date:
Therapist Signature:	Date: