Oliver Physical Therapy, PLLC at
Achievement Therapy & Wellness
2504 Genesee St, Suite IB
Utica, NY 13502
(315) 765-0063
atwcny.com

Welcome to
Physical Therapy Services
for
Balance, Vestibular and Concussion Conditions

Achievement Therapy & Wellness is a multi-specialty center including physical therapy, occupational therapy and a variety of health and wellness programs. Our mission is to positively impact the health and wellness of community members locally, nationally and globally. We believe in paying it forward. A portion of all our proceeds supports people with disability locally, nationally, and globally, through our rehabilitation clinic in Haiti.

Our physical therapy services, provided through Oliver Physical Therapy, PLLC, specializes in the evaluation and treatment of dizziness, balance, vestibular and concussion and neurological disorders. We also provide a full range of general medical, post-surgical, orthopedic and sports physical therapy for our clients.

What to Expect at your First Appointment?

Your first visit will include a variety of tests and measures to determine the most appropriate treatment plan for your condition. Your first appointment will last 60 – 80 minutes. Follow-up appointments are usually about 40 minutes.

Important!

- Bring this completed packet, your Photo ID and Insurance Card and List of Medications.
- Please arrive at least 15 minutes early to ensure all paperwork and authorizations are complete prior to your visit.

DOs and DON'Ts for Balance, Vestibular and Concussion Clients

1. Do not wear any makeup, including mascara, eye liner, or face lotions. These products might interfere with the recordings.

2. Do not drink alcoholic beverages for 48 hours before the testing.

3. Certain medications can influence the body's response to the test, thus giving a false or misleading result. If possible, please refrain from taking the following medications for 48 hours prior to your appointment.
    a. Anti-vertigo medicines: Anti-vert, Ru-vert, or Meclizine;
    b. Anti-nausea medicine: Atarax, Dramamine, Compazine, Antiver, Bucladin Phenergan, Thorazine, Scopalomine, Transdermal.

4. Vital medications SHOULD NOT be stopped. Continue to take medications for heart, blood pressure, thyroid, anticoagulants, birth control, antidepressants, and diabetes. If you are unsure about discontinuing a particular medication, please call your physician to determine if it is medically safe for you to be without them for 48 hours.

5. Eat lightly the day of your appointment. If your appointment is in the morning you may have a light breakfast such as toast and juice. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch.

6. Testing may cause a sensation of motion that may linger. If possible, we encourage you to have someone accompany you to and from the appointment. However, if this is not possible, try to plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

Patient Information

Name: _____ Middle: _____ Last: _____ ☐ Male ☐ Female
Address:_____ Apt/Unit: _____
City:_____ State:_____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Email: _____
Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Age: _____
Emergency Contact: _____ Phone #:_____
Relationship: _____
Do you live in a Skilled Nursing or Assisted Living Facility, or Rehab Center? Yes No
Name: _____ Phone #: _____
Are you receiving Home Care Services? Yes No
EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed
Employer:_____
Address:_____

Medical Doctor Information
Referring Physician:_____ Phone #: _____
Address:_____
City:_____ State:_____ Zip: _____
Family Physician:_____ Phone #: _____

Please state briefly the nature of your problem: _____

Consent for Treatment The patient/legal guardian authorizes ATW / Oliver Physical Therapy staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.
Initial here _____

Consent to Release Medical Information I authorize ATW / Oliver Physical Therapy Services to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and _____
Initial here _____

Cancellation/No Show Policy I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and affects other patients as well. Appointments missed without sufficient notice (less than 24 hours) will be charged a $25 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as patient.
Initial here _____

I hereby certify that I understand these rights I acknowledge that I have been informed of ATW/ Oliver Physical Therapy, PLLC's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information.
Initial here _____

I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.
Initial here _____

Signature (Patient/Legal Guardian): _____ **Date:** _____

Medical History (page 1)

PATIENT NAME:_____ **DATE:**_____

Do you have, or have you had, any of the following?

Neurologic
☐ Migraine
☐ Stroke/TIA
If so, when? _____
☐ Parkinson's Disease
☐ Seizures/ Epilepsy
☐ Concussion/Head Injury
If so, when? _____
☐ Multiple Sclerosis
☐ Alzheimer's / Dementia
☐ Other Neurologic _____

Cardiovascular
☐ Heart Attack
If so, when? _____
☐ Pacemaker
☐ Peripheral Arterial Disease
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Other Cardiovascular _____

Respiratory
☐ Breathing Difficulties
☐ Emphysema/COPD
☐ Asthma
☐ Other Respiratory _____

Other Health Issues
_____
_____
_____
_____
_____
_____
_____

Orthopedic
☐ Artificial Joints
If yes, which? _____
☐ Arthritis
☐ Back Problems
☐ Back Surgery
If so, when? _____
☐ Neck Problems
☐ Osteoporosis/Osteopenia
☐ Other Orthopedic _____
_____

Vision
☐ Cataracts
If removed, when? _____
☐ Glaucoma
☐ Macular Degeneration
☐ Other Vision _____

Other
☐ Cancer
Type: _____
☐ Diabetes
☐ Neuropathy
☐ Depression
☐ Anxiety
☐ Thyroid
☐ Gastrointestinal Problems
☐ Rheumatoid Arthritis
☐ Tobacco Use _____
If yes, how much? _____
_____
☐ Alcohol Use _____
If yes, how much? _____

Medical History (page 2)

PATIENT NAME:_____ **DATE:**_____

Please list all of your current medications and supplements

Prescription	Dosage	Frequency	Route	Reason

Over the Counter Medications	Dosage	Frequency	Route	Reason

Supplements & Vitamins	Dosage	Frequency	Route	Reason

Balance/Vestibular/Concussion Patient Questionnaire (page 1)

PATIENT NAME:_____ DATE:_____

Equilibrium disorders may appear with a variety of symptoms.
Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness.
Please answer the questions regarding your history and symptoms to the best of your ability.

How or when did your problem first occur?_____

How long did it last? _____

1. Do you experience any of the following sensations? Please read the entire list first.
Then put an 'X' in either the first box for YES or the second box for NO to describe your feelings most accurately.

Yes	No	
☐	☐	Do you experience motion, air or sea sickness?
☐	☐	Did you have motion sickness as a child?
☐	☐	Do you have a family history of motion sickness? ☐ Parent ☐ Sibling ☐ Child
☐	☐	Do you have migraine headaches?
☐	☐	Were you exposed to any solvents, chemicals, etc.?
☐	☐	Have you ever fallen? How many times? _____ Where? _____ ☐ Inside the home ☐ Outside the home
☐	☐	Are you afraid of falling?

2. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces.
If you do not experience dizziness, please go to the next section (3).

Yes	No	
☐	☐	My dizziness is constant? If you answered yes, please go to section 3. If in attacks, how often?_____
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	Is the dizziness provoked by head/body movement? If so, which direction?_____
☐	☐	Is the dizziness worse at any particular time of the day? If so, when?_____
☐	☐	Do you know of anything that will stop your dizziness or make it better? What?_____
☐	☐	What make your dizziness worse? _____
☐	☐	What occurs before an attack? _____
☐	☐	Do you know any possible cause of your dizziness?_____

Balance/Vestibular/Concussion Patient Questionnaire (page 2)

PATIENT NAME:_____ DATE:_____

3. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.

Yes	No	
☐	☐	Light headedness?
☐	☐	Swimming sensation in the head?
☐	☐	Blacking out or loss of consciousness?
☐	☐	Objects spinning or turning around you?
☐	☐	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	Tendency to fall..... to the right or left.
☐	☐	..... forward or backward
☐	☐	Loss of balance when walking..... veering to the right?
☐	☐	..... veering to the left?
☐	☐	Do you have trouble walking in the dark?
☐	☐	Do you have problems turning to one side or the other?
☐	☐	Nausea or vomiting?
☐	☐	Pressure in the head?

4. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.

Yes	No			
☐	☐	Double vision?	☐ Constant	☐ In Episodes
☐	☐	Blurred vision or blindness?	☐ Constant	☐ In Episodes
☐	☐	Spots before your eyes?	☐ Constant	☐ In Episodes
☐	☐	Numbness of face, arms or legs?	☐ Constant	☐ In Episodes
☐	☐	Weakness in arms or legs?	☐ Constant	☐ In Episodes
☐	☐	Confusion or loss of consciousness?	☐ Constant	☐ In Episodes
☐	☐	Difficulty in swallowing? Tingling around the mouth?	☐ Constant	☐ In Episodes
☐	☐	Difficulty speaking?	☐ Constant	☐ In Episodes

5. Do you have any of the following? Please check the box for either YES or NO and circle the ear involved.

Yes	No		
☐	☐	Difficulty in hearing?	☐ Both Ears ☐ Right Ear ☐ Left Ear
		When did this start? _____	Is it getting worse? _____
		Does the hearing change with your symptoms?	If so, how? _____
☐	☐	Noise in your ears?	☐ Both Ears ☐ Right Ear ☐ Left Ear
		Describe the noise?	
		Does the noise change with your symptoms? If so, how? _____	
☐	☐	Does anything stop the noise or make it better? _____	
☐	☐	Fullness or stuffiness in your ears?	☐ Both Ears ☐ Right Ear ☐ Left Ear
		Does this change when you are dizzy? _____	
☐	☐	Pain in your ears?	☐ Both Ears ☐ Right Ear ☐ Left Ear
☐	☐	Discharge from your ears?	☐ Both Ears ☐ Right Ear ☐ Left Ear

DHI Outcome Measure

1. **PLEASE RATE YOUR PAIN LEVEL AT REST:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN
2. **PLEASE RATE YOUR PAIN LEVEL WITH ACTIVITY:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN
3. **PLEASE MARK AN "X" IN THE APPROPRIATE BOX REGARDING YOUR DIZZINESS/IMBALANCE SYMPTOMS**

		YES	SOMETIMES	NO
P1	Does looking up increase your problem?			
E2	Because of your problem, do you feel frustrated?			
F3	Because of your problem, do you restrict your travel for business or recreation?			
P4	Does walking down the aisle of a supermarket increase your problems?			
F5	Because of your problem, do you have difficulty getting into or out of bed?			
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?			
F7	Because of your problem, do you have difficulty reading?			
P8	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?			
E9	Because of your problem, are you afraid to leave your home without having without having someone accompany you?			
E10	Because of your problem have you been embarrassed in front of others?			
P11	Do quick movements of your head increase your problem?			
F12	Because of your problem, do you avoid heights?			
P13	Does turning over in bed increase your problem?			
F14	Because of your problem, is it difficult for you to do strenuous homework or yard work?			
E15	Because of your problem, are you afraid people may think you are intoxicated?			
F16	Because of your problem, is it difficult for you to go for a walk by yourself?			
P17	Does walking down a sidewalk increase your problem?			
E18	Because of your problem, is it difficult for you to concentrate?			
F19	Because of your problem, is it difficult for you to walk around your house in the dark?			
E20	Because of your problem, are you afraid to stay home alone?			
E21	Because of your problem, do you feel handicapped?			
E22	Has the problem placed stress on your relationships with members of your family or friends?			
E23	Because of your problem, are you depressed?			
F24	Does your problem interfere with your job or household responsibilities?			
P25	Does bending over increase your problem?			

SECTION II - Instructions: Put a check in the box that best describes you:

☐ Negligible symptoms (0)

☐ Bothersome symptoms (1)

☐ Performs usual work duties but symptoms interfere with outside activities (2) ☐ Symptoms disrupt performance of both usual work duties and outside activities (3)

☐ Currently on medical leave or had to change jobs because of symptoms (4)

☐ Unable to work for over one year or established permanent disability with compensation payments (5)

For Office Use Only Score P: _____ E: _____ F: _____ 16-34 Points (mild) 36-52 Points (moderate) 54+ Points (severe)