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physical therapy and wellness center

PELVIC FLOOR TREATMENT PATIENT REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:
Address:	City:	State: Zip:
Home Phone:	Cell:	Email:
Date of Birth: Sex:	Marital Status:	
Employer:		Work Phone Number:
Emergency Contact:	Phone Number:	Relationship:

Referring Doctor (if referred):	Primary Care Doctor:
Date of Onset of Symptoms:	Physical Therapy is for treatment of:

How did you hear about Pinamonti Physical Therapy? (Circle one - if "Other" please specify)

Doctor Friend/Relative Radio Print TV Internet Phone Book Employer Other _____

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MEDICAL HISTORY QUESTIONNAIRE
PFT

Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Describe the current problem: _____

_____

When did the problem begin? _____

Has the problem stayed - The Same | Better | Worse

Do you have pain? Y / N

Please rate the pain 0 - 10 _____ (0 is no pain, 10 is horrible pain)

Please describe the type of pain: _____

Have you had previous treatments? _____

Have you fallen in the past year? _____ How many times? _____

Pain

Y / N Pain wearing tight clothing?
Y / N Pain with sitting?
Y / N Pain with bowel movement?
Y / N Pain with speculum exams?
Y / N Pain with sexual intercourse?
Y / N Pain worsens with walking?
Y / N Require pain medication?
Y / N Limited social outings due to pain?
Y / N Pain inserting tampon?

Activities/events that cause or aggravate your symptoms. Check/circle all that apply.

__ Sitting greater than _____ minutes
__ Walking greater than _____ minutes
__ Standing greater than _____ minutes
__ Changing positions (i.e - sit to stand)
__ Light activity (light housework)
__ Vigorous activity/exercise (run/weight lift/jump)
__ Sexual activity
__ With cough/sneeze/straining
__ With laughing/yelling
__ With lifting/bending
__ With cold weather
__ With triggers - running water/key in door
__ With nervousness/anxiety
__ No activity affects the problem

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How has your lifestyle/quality of life been altered/changed because of this problem?

_____

Have social activities been affected? Y / N Specify (exclude physical activities)

_____

Has diet/fluid intake been affected? Y / N Specify _____

Has physical activity been affected? Y / N Specify _____

Has work been affected? Y / N Specify _____

Other _____

Rate the severity of this problem from 0-10 (0 being no problem and 10 being the worst) _____

What relieves your symptoms? _____

What are your treatment goals/concerns? _____

Since the onset of your current symptoms have you had:

Y / N Fever/Chills
Y / N Unexplained weight change
Y / N Dizziness or fainting
Y / N Change in bowel or bladder functions
Y / N Malaise (Unexplained tiredness)
Y / N Unexplained muscle weakness
Y / N Night pain/sweats
Y / N Numbness/Tingling

Other / Describe: _____

Health History: Date of Last Physical Exam _____ Tests performed _____

_____

General Health: Excellent | Good | Average | Fair | Poor

Occupation: _____

Hours/week _____ **On disability or leave?** _____ **Activity Restrictions?** _____

Mental Health: Current level of stress High _____ Medium _____ Low _____

Current psychological therapy? Y / N

Activity/Exercise: None | 1-2 days/week | 3-4 days/week | 5+ days/week

Describe: _____

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Have you ever had any of the following conditions or diagnoses? Circle all that apply/describe:

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands & feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe: _____

Surgical/Procedure History

Y / N Surgery for your back/spine	Y / N Surgery for your bladder/prostate
Y / N Surgery for your brain	Y / N Surgery for your bones/joints
Y / N Surgery for your female organs	Y / N Surgery for your abdominal organs

Other/Describe: _____

Ob/Gyn History (females only)

Y / N Childbirth vaginal deliveries # _____	Y / N Vaginal dryness
Y / N Episiotomy # _____	Y / N Painful periods
Y / N C-Section # _____	Y / N Menopause - when? _____
Y / N Difficult childbirth # _____	Y / N Painful vaginal penetration
Y / N Prolapse or organ falling out	Y / N Pelvic Pain

Other/Describe: _____

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Males Only

Y / N Prostate disorders
Y / N Shy bladder
Y / N Pelvic Pain
Y / N Erectile dysfunction
Y / N Painful ejaculation

Other/Describe: _____

Medications - pills, injection, patch	Start date/dosage	Reason for taking

Over the counter vitamins, etc.	Start date/dosage	Reason for taking

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y / N Trouble initiating urine stream
Y / N Urinary intermittent / slow stream
Y / N Trouble emptying bladder
Y / N Difficulty stopping the urine stream
Y / N Trouble emptying bladder completely
Y / N Straining or pushing to empty bladder
Y / N Dribbling after urination
Y / N Constant urine leakage
Y / N Pain with bowel movement
Y / N Trouble emptying with bowel movement
Y / N Leaking of feces
Y / N Abdominal pain
Y / N Blood in urine
Y / N Painful urination
Y / N Trouble feeling bladder urge/fullness
Y / N Current laxative use
Y / N Trouble feeling bowel/urge/fullness
Y / N Constipation/straining
Y / N Trouble holding back gas
Y / N Recurrent bladder infections
Y / N Pain with sexual intercourse
Y / N Smearing of feces in underwear
Y / N Feelings of bloating or gassiness

Frequency of urination: Times per day _____
Times per night (during bedtime) _____

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? _____

The usual amount of urine passed is: ____ Small ____ Medium ____ Large

Frequency of bowel movement: _____

Do you have a regular bowel schedule? Y / N

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____

If constipation is present, please describe management techniques:

_____

What is the consistency of bowel movements: Hard | Soft Solid | Soft not solid

Average fluid intake (one glass is 8 oz. or one cup) _____ glasses per day.

Of this total how many glasses are caffeinated? _____ glasses per day.

Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___ None present

___ Times per month (specify if related to activity or your period)

___ With standing for _____ minutes or _____ hours.

___ With exertion or straining

___ Other: _____

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Skip this page if you don't experience leakage/incontinence

Bladder leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

Bowel leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

On average, how much urine do you leak?

___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

How much stool do you lose?

___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying
___ Is the stool formed or loose?

What form of protection do you wear? (Please complete only one)

___ None
___ Minimal protection (Tissue paper/paper towel/pantishields)
___ Moderate protection (absorbent product, maxipad)
___ Maximum protection (Specialty product/diaper)

___ Other _____

On average, how many pad/protection changes are required in 24 hours? _____ # of pads

1014 Mt Carmel Pl, Pittsburg, KS 66762 Phone: (620) 235-1500 Fax: (620) 235-1508

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Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your physician, orthopedic surgeon etc.) in connection with our rendering physical therapy treatment to you (i.e., to determine the appropriate plan of care, treatment etc.);

- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);

- To certifying, licensing and accrediting bodies (i.e., the Kansas State Board of Healing Arts, etc.) in connection with obtaining certification, licensure or accreditation;

- Internally, to all staff members who have any role in your treatment;

- To your family and close friends involved in your treatment; and/or,

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- We may mail appointment reminders in postcard form, leave messages about appointments on answering machines, which may be read or overheard by others.

- We may use or disclose your health information when we are required to do so by law.

- We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

-continued-

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.
Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

You may refuse to Sign This Acknowledgement

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____
Patient or Guardian Signature: Date:

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communications barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__ Other _____

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CONDITIONS & CONSENT FOR TREATMENT

I understand that I am a patient of Pinamonti Physical Therapy and Wellness Center. My care is the exclusive responsibility of my treating therapist, not of any other practitioners who also may practice at this location.

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region, including the vagina and/or rectum.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential benefits: May include an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Cooperation with treatment:

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy:

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $50. If I do not show for my appointment and do not call to cancel I will pay the full fee of $100.00 for my treatment session.

No warranty:

I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated.

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Release of medical records:
I authorize the release of my medical records to the following physicians/primary care provider or insurance company:

_____
_____
_____
_____
_____
_____

Financial and insurance responsibilities:
I agree to pay for my treatments at time of service by cash, check, or charge card. I understand it is my responsibility to call my insurance company ahead of time and obtain any pre-authorization that is necessary, and get an estimate of my benefits. Insurance reimbursement, if any, is to be handled between the patient and their insurance company.

Rates:
Evaluation $125
Treatment $100
$25 / 15 minutes over one hour
Dry Needling $25 / 15 minutes.

I have read the above information and I consent to physical therapy evaluation and treatment.

_____ _____
Print Name Date

_____ _____
Patient or Guardian Signature Date