The Physical Therapy Effect

PATIENT INFORMATION

Please present your insurance card and driver's license for copying

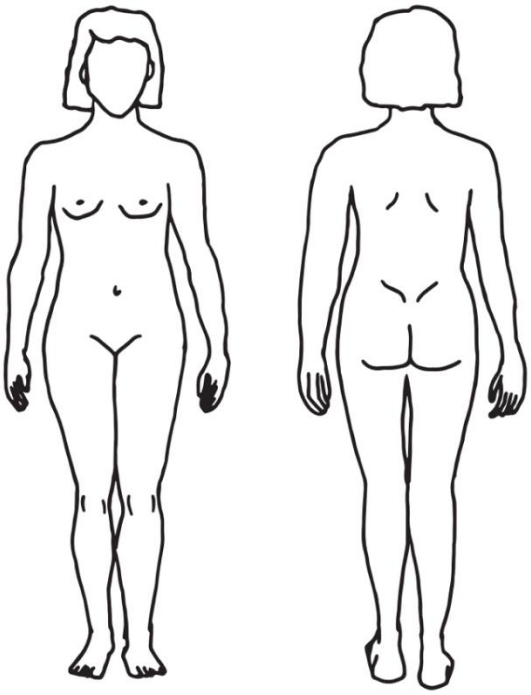
Patient Name:	Sex:	Date of Birth:	Age:	Height:	Weight:
Address:				Marital Status:	

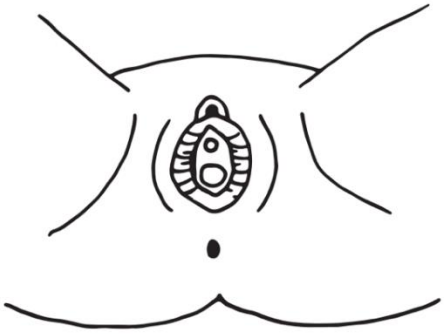
*You will be meeting with a Pelvic Floor Therapist in a private treatment room. A chaperone is available to you upon your request. Would you like a chaperone present?

- ☐ Yes
- ☐ No

Mobile Phone:	Work Phone:	Employer:
E-Mail Address:		Referring MD:
How did you hear about us: (circle one)	Internet Friend Doctor Walk In Other_____	
Social Security Number (Tricare Patients Only):		
Emergency Contact:	Relationship:	Home Phone:
What brings you here today?		**How long have you had this problem for?**

Pain/body map: Please mark where you experience pain





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1) With regards to this injury or pain, was surgery performed?

☐ Yes ☐ No

If so, Type: _____ Date of Surgery: _____

2) Was the onset/time of this episode:

☐ Gradual ☐ Sudden

3) Since the onset, are your symptoms getting:

☐ Better ☐ Worse ☐ Staying the Same

4) Nature of pain/symptoms: (mark all that apply)

☐ Sharp
☐ Aching
☐ Dull
☐ Throbbing
☐ Periodic
☐ Constant
☐ Occasional
☐ Other:_____

5) Rate your pain on scale of 0-10 below. Place 3 circles: (Best, Current, Worst)

Best - 0 1 2 3 4 5 6 7 8 9 10

Current - 0 1 2 3 4 5 6 7 8 9 10

Worst - 0 1 2 3 4 5 6 7 8 9 10

6) As the day progresses, do your symptoms:

☐ Increase ☐ Decrease ☐ Stay the Same

7) Does your pain wake you at night:

☐ Yes
☐ No
☐ While lying down
☐ Only with changing positions

8) What Position do you sleep? (mark all that apply)

☐ Back ☐ Chair/recliner ☐ Left side
☐ Stomach ☐ Right side

9) Average amount of sleep per night? _____

10) Occupation:_____ Employer:_____

☐ Full Time ☐ Self Employed ☐ Retired
☐ Part Time ☐ Student ☐ Unemployed

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11) Previous Functional Level: (mark all that apply)

- ☐ Independent in all activities
- ☐ Independent in all self-care
- ☐ Difficulty performing self-care activities
- ☐ Need assistance with self-care activities
- ☐ Difficulty performing household chores
- ☐ Need assistance with activities in community outside of home

12) Current Functional Level: What specific activities are you unable to do because of your symptoms?

_____

13) What positions, activities, and time of day aggravate your symptoms?

_____

14) What positions, activities, and time of day relieve your symptoms?

_____

15) Have you had previous treatment for this condition? (mark all that apply)

- ☐ Medication
- ☐ Injection
- ☐ Manipulation DC/DO
- ☐ Exercise
- ☐ Other _____
- ☐ Physical Therapy
- ☐ Traction
- ☐ Naturopathic Doctor
- ☐ Acupuncture
- ☐ Injection
- ☐ Bracing/Taping
- ☐ Massage Therapy
- ☐ Oriental Medicine

16) Have you had any tests done relating to your condition? (mark all that apply)

- ☐ X-ray
- ☐ MRI
- ☐ Lab Tests Results: _____
- ☐ CT Scan
- ☐ Bone Scan
- ☐ Arthrogram

17) Are you currently taking any medications or supplements, either prescription or over the counter? Please List.

_____

_____

18) Do you have any allergies to food or medications?

_____

19) How would you rate your general health?

- ☐ Excellent
- ☐ Good
- ☐ Average
- ☐ Fair
- ☐ Poor

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20) Have you had any falls this year; if yes, how many times have you fallen this year?

☐ Yes, # of falls_____ ☐ No

21) Do you have a prior or current history of smoking?

☐ No ☐ Yes

22) How frequently do you exercise outside of normal daily activities?

☐ 5+ days/wk ☐ 1-2 days/wk
☐ 3-4 days/wk ☐ Occasionally
☐ Zero

What type(s) of exercise/sports? _____

23) What are your goals coming to Physical Therapy?

_____

24) Please indicate your activity level due to your present condition as compared to your previous level before injury.

☐ Inactive ☐ Normal

25) Past Surgical History:

☐ Types of Surgery and Surgical Dates: _____

☐ Types of Surgery and Surgical Dates: _____

30) Additional Comments you would like to add:

_____

_____

_____

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MEDICAL HISTORY

As you review the following list, please check any problems or conditions that you are currently experiencing or have experienced.

General Health

- ☐ Good General Health
- ☐ Recent weight change
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Chronic Fatigue Syndrome
- ☐ Fever/Chills
- ☐ Other:_____

Spine/Orthopedic/Bone

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Joint Pain
- ☐ Muscle Pain/Stiffness
- ☐ Difficulty Walking
- ☐ Fractures
- ☐ Dislocations
- ☐ Swelling
- ☐ Other:_____

Ears, Eyes, Nose, Mouth, Throat

- ☐ Change in Taste/Smell
- ☐ Change in swallow/chewing
- ☐ Ringing in Ears
- ☐ Sinus Infection
- ☐ Recent dental work
- ☐ Change in Vision
- ☐ Other:_____

Gastrointestinal

- ☐ Constipation/Diarrhea
- ☐ Nausea/Vomiting
- ☐ Painful Bowel Movements
- ☐ Stomach/Abdominal Pain
- ☐ Ulcer
- ☐ Crohns
- ☐ Bowel Incontinence
- ☐ Other:_____

Rheumatologic

- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Auto-Immune Disorders
- ☐ Psoriatic Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Other:_____

Skin

- ☐ Cellulitis
- ☐ Psoriasis
- ☐ Hives
- ☐ Rash/Itching
- ☐ Other:_____

Blood

- ☐ Deep Vein Thrombosis
- ☐ Arteriosclerosis
- ☐ Artery Bypass Surgery
- ☐ HIV/AIDS
- ☐ Cancers
- ☐ Other:_____

Cancer

- ☐ History of Cancer - Type:_____ Treatment:_____
- ☐ Blood Disorder Other:_____

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Cardiac

- ☐ History of Heart Attack
- ☐ Angina
- ☐ Implantable Defibrillator
- ☐ Pacemaker
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Bypass surgery
- ☐ Other:_____

Neurologic

- ☐ Seizure
- ☐ Concussion
- ☐ Traumatic Brain Injury
- ☐ Stroke
- ☐ Disc Bulge/Herniation
- ☐ Dizziness/Vertigo
- ☐ Memory Loss
- ☐ Migraine Headaches
- ☐ Balance Difficulties
- ☐ Other:_____

Psychiatric

- ☐ Severe Depression
- ☐ Panic Attack
- ☐ Psychotic Disorder
- ☐ Borderline Disorder
- ☐ Suicide Attempt
- ☐ Other:_____

Pelvic Floor Medical History:

Reproduction

- ☐ Testicular Pain
- ☐ Prostate Disease
- ☐ Sexual Difficulty
- ☐ Irregular Periods
- ☐ # Pregnancies:_____
- ☐ If Pregnant # of weeks:_____
- ☐ Currently Breastfeeding
- ☐ STD
- ☐ Endometriosis
- ☐ Oral Birth Control Pills
- ☐ Ovarian Cysts
- ☐ PCOS
- ☐ Pelvic Pain
- ☐ Menopause
- ☐ Trying to Conceive
- ☐ Other:_____

Please list date(s) and outcome of pregnancies (i.e vaginal delivery, cesarean section, miscarriage, abortion):

_____

_____

Urinary (Select all that apply)

- ☐ Kidney Stones/Infection
- ☐ Frequent UTI/Bladder Infections
- ☐ Urinary Incontinence/Urgency
- ☐ Urinary Retention
- ☐ Painful Urination
- ☐ Incomplete Urination
- ☐ Urinary Leakage
- ☐ Other: _____

How many times do you urinate per day? _____Within an hour _____Within a day

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Do you experience any urinary leakage with the following activities? (Select all that apply)

☐ N/A ☐ Sneezing ☐ Jumping
☐ Coughing ☐ Laughing ☐ Exercise

Do you wake up in the middle of the night to urinate?

☐ Yes, if yes how many times? _____ ☐ No

Bowel History

Do you experience stool leakage?

☐ Yes ☐ No

If yes, how often? _____ What causes leakage? _____

How often do you have bowel movements during the week? _____

Do you experience pain with bowel movements?

☐ Yes ☐ No

Do you have to use medications to have a bowel movement?

☐ Yes, if yes what do you use and how often? _____
☐ No

Do you splint or use your fingers to assist with having a bowel movement?

☐ Yes ☐ No

Do you experience any other bowel problems? If so, please explain: _____

_____

_____

Sexual History

Are you currently sexually active?

☐ Yes ☐ No

If "no" have you been sexually active in the past?

☐ Yes ☐ No

If "yes" are you currently refraining from sexual activity because of the problem bringing you here

☐ Yes ☐ No

Does your sexual practice (past or present) include any anal entry activities?

☐ Yes ☐ No

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Do you experience/have you experienced painful intercourse (Dyspareunia)?

☐ Yes ☐ No

If yes, is the pain with initial penetration or is it located deeper? _____

During a gynecological exam, do you have pain with the speculum?

☐ Yes ☐ No

Do you have low sex drive?

☐ Yes ☐ Unsure

☐ No

Have you EVER been on oral contraceptives ("the pill", NuvaRing, implant, or Shot)?

☐ Yes ☐ No

What do you currently use for birth control? _____

Any Additional Comments you would like to add?:

_____

_____

_____

_____

_____

_____

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Office Payment Policy

Please initial your payment method and sign below that you have read, understand, and agree with all the information on this page:

_____ 1. PRIVATE HEALTH INSURANCE (PPO): Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility of a deductible (amount paid by the patient before the insurance policy begins payment for services) and either a copay (a set dollar amount per visit) or coinsurance (a percent of the allowed charges). Deductibles and copays are due at the time of service. We will bill you for your coinsurance or other remaining payments due after we have been paid by your insurance or notified of their denial for payment.

_____ 2. VA: Authorization from your insurance must be obtained prior to treatment. Any copay or coinsurance is due at the time of treatment.

_____ 3. MEDICARE: The Physical Therapy Effect, P.C. is a certified participating Medicare provider. Medicare has an annual deductible of $186.00 and an annual benefit limit of $2040.00 for PT and Speech combined. Secondary insurance plans may cover the patient portion due until your Medicare benefits are exhausted. Please verify all your insurance benefits and be sure you understand your insurance coverage.

_____ 4. Cash, Check or Card: Payment will be due at time of service unless an agreed upon monthly payment plan has been agree upon with The Physical Therapy Effect.

_____ 5. WORKER'S COMPENSATION/ AUTO CLAIMS: Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office manager with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.

Adjuster Name: _____ Claim Number: _____

Financial Provider Name: _____ Date of Incident: _____

ATTENTION AUTO ACCIDENT VICTIMS AND WORKER'S COMPENSATION INJURY PATIENTS:
Please sign a release of information authorizing us to discuss your treatment with your attorney

I have reviewed this office policies statement and initialed next to my payment method. I have discussed it with the clinical office manager and all my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Signature: _____ Date: _____

CMM Rev. 4/2006

(Failure to sign this form absolves The Physical Therapy Effect, P.C. of responsibility of billing patient's insurance, if pertinent.)

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CONDITIONS OF REGISTRATION

Patient Name: _____ DOB: _____

1. Release of Information: I authorize **The Physical Therapy Effect (TPTE)** to release my medical records to my health insurance for the purpose of billing and processing of my claim. I also agree to allow The Physical Therapy Effect to release my medical records and discuss health related and financially related issues to all health care providers, case managers, insurance representatives and lawyers that are involved in my case. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

2. Assignment of Insurance Benefits / Financial Responsibility: The Physical Therapy Effect has my permission to submit billings to my insurance company on my behalf and I authorize these payments to be made directly to The Physical Therapy Effect. I agree to pay all outstanding balances on my account within 60 days of receiving a balance due statement. Should my account be referred to an attorney, I will pay actual attorney fees. **I acknowledge that verification of insurance benefits is provided as a courtesy and NOT a guarantee of payment.**

3. Notice of Privacy Practices: I acknowledge that I have been offered a copy of The Physical Therapy Effect's notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by TPTE and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

4.Cancellation, No Show and or Missed Appointments: A total of 3 consecutive absent appointments will result in the removal of all pre scheduled future appointments, it also allows TPTE to call my primary care doctor and or my financial provider and inform them of my absences which may lead to denial of coverage of future appointments by my financial provider.

5. Consent for Care and Treatment: I, the undersigned, hereby and give my consent for The Physical Therapy Effect, P.C. to furnish medical care and treatment as considered necessary and proper in diagnosing or treating his/her physical condition.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to The Physical Therapy Effect, and I understand that I am financially responsible for any remaining balance owed to The Physical Therapy Effect. I certify that I have read, understand, and agree to all the conditions of registration, and request and consent to the above-named patient to receive appropriate services from The Physical Therapy Effect.

Patient / Guarantor Signature: _____ Date: _____

Print Patient / Guarantor Name: _____Relationship: _____