Providence Physical Therapy

Thank you for choosing us for your physical therapy needs. In order to best serve you, please fill out the following information in ink. Please note all of your information will be kept confidential. If you have any questions, please feel free to ask us for assistance.

Patient Information

Today's Date:__________________________ Date of Birth: ________________________________
Name: ________________________________ Email: _____________________________________
Cell Phone #: __________________________ Home Phone #: ______________________________
Work Phone #:__________________________ Driver's License #:___________________________
Employer: _____________________________ Occupation:__________________________________
Employer's Address:____
Street City State Zip Code

Emergency Contact Information (not living with you)

Name: ________________________________Relationship: ________________________________
Home Phone #: ________________________ Work Phone #: _______________________________
Address: ____
Street City State Zip Code

Responsible Billing Party (if not the patient)

Name: ________________________________Relationship:_________________________________
Work Phone #: __________________ Home Phone #: _________________ SS #: ______________
Employer: ___________________________________Occupation: ___________________________
Billing Address:____
Street City State Zip Code

Spouse Information

Name: _________________________Birthdate: ________________SS #: _____________________
Employer: ___________________________________Occupation: ___________________________
Work Phone #: _________________________ Cell Phone #: _______________________________

Additional Information

When & Where are the best times to reach you? ____
How did you find out about us or whom can we thank for referring you to us? _______________
____

Cancellation Policy

Should you need to cancel an appointment we ask that at you provide us with notice at least 24 hours in advance. For failure to come to your scheduled appointment or to give advanced notice, our policy is to assess your account a minimum of $90. Please help us serve you better by keeping scheduled appointments.

Signature: ____ Date:________________________________

Office Information:

Account #: __________ PT: _________ Dx Codes: ________________ Location: _________

PROVIDENCE PHYSICAL THERAPY

Assignment of Benefits, Consent for Release of Information, and Notice of Privacy Practice

Patient: ____ SS#/ID#: ________________________________
Employer: ______________________________________ Claim Group: _____________________________

Assignment of Benefits

I hereby instruct and direct ______________________________Insurance Company to pay by check which should be made out and mailed to: Providence Physical Therapy, P. O. Box 21150, Boulder, CO 80308. However, if my current insurance policy does not allow direct payment to my provider, I hereby instruct you to make out the check to me and mail it to the following address: Providence Physical Therapy, P. O. Box 21150, Boulder, CO 80308.

This is for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy for the services rendered. I authorize Providence Physical Therapy to deposit checks received on my account when made out to me. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I understand that billing for services rendered is a courtesy and that it is my individual responsibility to be informed about my insurance benefits and payment obligations. All information provided to me by the administrative and billing staff of Providence Physical Therapy is the best estimate based on information provided to them by my insurance company at the time of benefit verification.

A photocopy of this Assignment shall be considered as valid and effective as the original.

Consent of Release of Information

I also authorize the release of any information pertinent to my case to any physicians, rehabilitation consultants, insurance company, adjuster, or attorney involved in this case, except as follows:

____

Signature of Policyholder:____Date: _______________
Signature of Claimant, if other than Policyholder: ____

Please list persons with whom we may leave confidential information:

Name ____ Phone:_____________________
Name____ Phone:_____________________

Only speak to me regarding my medical case. ☐ Yes

How may we leave confidential information with you?

Email: ____ Home Voice Mail:________________________
Cell Phone Voice Mail: ____________________________ Work Voice Mail: ________________________

Acknowledgement of Receipt of Notice of Privacy Practices/HIPAA

I, _______________________________, have been provided with a copy of the Notice of Privacy Practices from Providence Physical Therapy.

Signature:____ Date: ____________________

In lieu of a patient signature, I, __________________________________, a staff member of Providence Physical Therapy, state that the above named patient was offered our Notice of Privacy Practices.

Signature:____ Date: ____________________

Medical History Intake Form

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

Name:___________________________________ **Occupation**:_____________________________________

Leisure Activities:____

Allergies:
List any medication(s) you are allergic to:____
Are you latex sensitive? YES NO
List any other allergies we should know about ____

Please check (√) any of the following whose care you are under
___ Medical doctor (MD) ___Psychiatrist/Psychologist Other _________________
___ Osteopath ___ Physical Therapist _________________
___ Dentist ___ Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):____
____
____

Personal Medical History:
Have you EVER been diagnosed as having any of the following conditions?
YES NO Cancer. If YES, describe what kind: _______________
YES NO Heart Problems
YES NO High blood pressure
YES NO Circulation problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical dependency (i.e., alcoholism)
YES NO Thyroid problems
YES NO Diabetes
YES NO Multiple sclerosis
YES NO Rheumatoid arthritis
YES NO Other arthritic conditions
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease
YES NO Anemia
YES NO Epilepsy
YES NO Other___________________

For Office Use

Medical History Intake Form

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Are you currently or have you in the past experienced sexual abuse? YES NO

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date	Reason for Surgery/Hospitalization
1.	
2.	
3.	
4.	
5.	
6.	

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date		Date	Injury
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

Describe your current general health:____

____

Medical History Intake Form

Family Medical History:

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES	NO	Diabetes	YES	NO	Cancer
YES	NO	Tuberculosis	YES	NO	Arthritis
YES	NO	Heart disease	YES	NO	Anemia
YES	NO	High blood pressure	YES	NO	Headaches
YES	NO	Stroke	YES	NO	Epilepsy
YES	NO	Kidney disease	YES	NO	Mental illness
YES	NO	Alcoholism (chemical dependency)			

Medications:

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

YES NO Aspirin
YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Laxatives
YES NO Decongestants
YES NO Antihistamines
YES NO Antacid
YES NO Vitamins/mineral supplements
YES NO Other ___________________________

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. ________________________ 2.___________________________ 3.________________________________
4. ________________________ 5. ___________________________6.________________________________

If you take vitamins or herbals, please list them:____

____

Describe your current exercise routine and/or physical activities:___________________________________

____

How many caffeinated coffee or caffeine containing beverages do you drink per day? _________
How many packs of cigarettes do you smoke a day? ________
How many days per week do you drink alcohol? ________
If one drink equals one beer, one glass of wine, or one mixed drink, how much do you drink at an average sitting? ________

Have you recently noted:

YES NO weight loss/gain
YES NO nausea/vomiting
YES NO dizziness/lightheadedness
YES NO fatigue
YES NO weakness
YES NO fever/chills/sweats
YES NO numbness or tingling

____ ____________________________

Patient Signature Date

Urogynecology/Urology Intake Form

Patient Name: ____ Date: _____________________

Female ☐ Male ☐ Age:__________ Height:_____________ Weight:___________________

Referring Physician:____

Date of injury onset and/or date of surgery:____

Is this injury the result of a motor vehicle accident? Yes ☐ No ☐

Is this injury the result of an accident while at work? Yes ☐ No ☐

Chief Complaints:____

History/Onset of symptoms or injury (i.e. *How did these symptoms begin?*):_________________________

____

Symptoms aggravated by:____

Symptoms relieved by:____

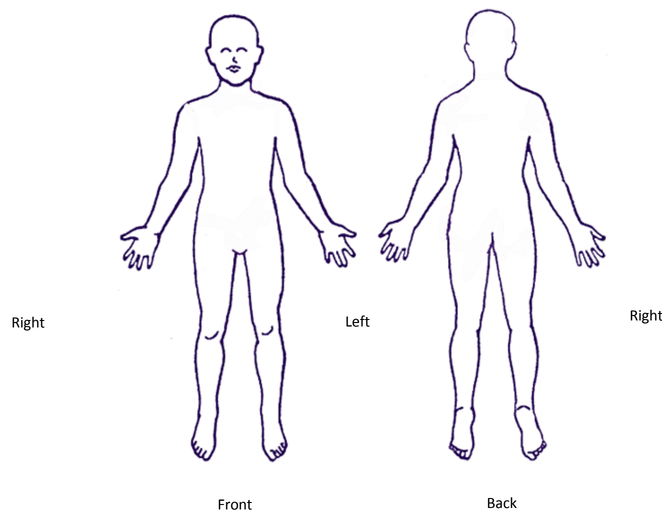
Nature of pain:

†Throbbing †Sharp † Cramping

†Aching †Stabbing †Shooting

†Sore †Burning †Tingling

Please indicate on the diagram of the body the areas that are symptomatic. Please use X's to specify the area(s) of the body to which you are referring.



Pelvic Symptom Questionnaire

Have you experienced any of the following bladder/bowel habits and/or 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 Straining or pushing to empty bladder
Y N Dribbling after urination
Y N Constant urine leakage
Y N Blood in urine
Y N Painful urination
Y N Trouble feeling bladder urge/fullness
Y N Trouble feeling bowel urge/fullness
Y N Constipation/straining
Y N Trouble holding back gas/feces
Y N Recurrent bladder infections
Other: ____

Please answer the following questions related to your bowel and bladder habits:

1. Frequency of urination: awake hour's: ______ times a day; sleep hours _____ times per night.

2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   a. _________ minutes, __________ hours, __________ not at all.

3. The usual amount of urine passed is: ____ small ____ medium ____ large

4. Frequency of bowel movements: _____ times a day, _____ times a week or other?_____________________.

5. When you have the urge to have a bowel movement, how long can you delay before you have to go to the toilet?
   a. _________ minutes, _______ hours, ___________ not at all.

6. If constipation is present describe the management techniques you use:_____________________
   ____

7. Average fluid intake (one glass is 8 oz or one cup) ___________ glasses per day.
   Of this total how many are caffeinated? ________ glasses per day.
   What type of beverage(s)? ____

8. Rate a feeling of organ "falling out"/prolapsed or pelvic heaviness/pressure:
   __ None present
   __ Time per month (specify if related to activity or your menstrual cycle)
   __ With standing for ________ minutes or ________ hours
   __ With exertion or straining
   __ Other

Skip the following questions if no leakage/incontinence occurs:

9a. Bladder leakage-number of episodes
__ No leakage
__ Times per day
__ Times per week
__ Times per month
__ Only with physical exertion/cough

9b. Bowel leakage-number of episodes
__ No leakage
__ Times per day
__ Times per week
__ Times per month
__ Only with physical exertion/cough

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

11. What form of protection do you wear? (Choose 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?
_______ number of pads

12. 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 (e.g.: sit to stand)

Light activities (light housework)

Vigorous activities/exercise (run/weight lift/jump)

No activity affects the problem

With cough/sneeze/straining

With laughing/yelling

With lifting/bending

With cold weather

With triggers (running water, key in door)

With nervousness/anxiety

Other, please list: ___________________

13. How has your lifestyle/quality of life been altered or changed because of the problem?
____

Social activities (exclude physical/sport activities), specify: ____
____

Diet/fluid intake, specify:____
____

Physical activities:____
____

Work, specifiy:____
____

Other, specify:____
____

14. Rate the severity of the problem from 0-10 with 0 being no problem and 10 being the worst:

15. How long have you had a urinary leakage/incontinence problem?
______ months _____ years

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment will be explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

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. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal or rectal examination or and/or use of sensors for muscle biofeedback.

Treatment may include, but not be limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal palpation or use of sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold stretching and strengthening exercises, soft tissue and/or join mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist. Potential benefits may include an improvement in my symptoms and an increase in my ability to perform my 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.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all 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. I hereby request and consent to the evaluation and treatment by my provider.

Patient Name ______________________________ Date ______________________________
(Please Print)

______________________________ ______________________________
Patient Signature Signature of Parent or Guardian (if applicable)