PELVIC FLOOR INTAKE FORM

PATIENT INFORMATION

First Name: Last Name: Middle Initial: Date:

Address: City: State: Zip:

Birth date: Age: ☐ Male ☐ Female S.S. #:

Home Phone: Alternative Phone (Cell, Work): Spouse:

E-mail Address: Height: Weight:

Chose Clinic Because: ☐ Doctor ☐ Insurance ☐ Family/Friend ☐ Former Patient ☐ Yellow Pages ☐ Other

Whom may we thank for your referral:

WORK INFORMATION

Employer: Work Phone: Extension:

Occupation: Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Employed

CARE PROVIDER INFORMATION

Referring Doctor: Referring Doctor Phone:

Regular Doctor/PCP: Regular Doctor/PCP Phone:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:

Subscriber's Name (If different): Birth date:

ID #: Group/Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Secondary Insurance:

Subscriber's Name: Birth date :

ID #: Group/Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR PRIVATE HEALTH INSURANCE INFORMATION FOR BACKUP)

Insurance Name: Auto/Workers Comp:

Adjuster/Claim Manager: Phone: Extension:

Address: City: State: Zip:

Claim #: Accident Date: Cause:

ATTORNEY INFORMATION

Name: Law Firm: Phone:

Address: City: State: Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative:

Relationship to Patient: Home Phone: Work Phone:

I authorize my insurance benefits be paid directly to Elite Physical Therapy I understand that I am financially responsible for any balance. I also authorize Elite Physical Therapy to release any information required to process my claims.

Patient/Guardian Signature Date

Kelly M. Floyd, MPT
Lesley A.Tedesco, DPT, ATC

Elite Physical Therapy

2630 E. 7th Street, Suite 206 • Charlotte, NC 28204
704.333.1052 • Fax 704.333.1054

Patient History

Name ____Age_________ Date_______________

1. Describe the current problem that brought you here?____
____

2. When did your problem first begin?___months ago or ___ years ago.

3. Was your first episode of the problem related to a specific incident? Yes No
Please describe and specify date ____
____

4. Since that time is it: staying the _____ same ________ getting worse ________ getting better
Why or how?____

5. If pain is present rate pain on a 0-10 scale 10 being the worst._______ Describe the nature of the pain (i.e. constant burning, intermittent ache)___________________________________
6. Describe previous treatment/exercises____
____

7. 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 (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list ____
___ 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

8. What relieves your symptoms?____
____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify___________________________________
Diet /Fluid intake, specify ____
Physical activity, specify ____
Work, specify ____
Other ____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst __

11. 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 Other /describe
Y N Malaise (Unexplained tiredness)
Y N Unexplained muscle weakness
Y N Night pain/sweats
Y N Numbness / Tingling

 Name____

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___ Med___ Low___ Current psych therapy? Y N
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe ____

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 and 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

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
Y	N	Other /describe____			

Medications - pills, injection, patch   Start date   Reason for taking
____
____
____
____

Over the counter -vitamins etc   Start date   Reason for taking
____
____
____
____

 Name______________________________________

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 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/feces
Y N Recurrent bladder infections
Y N Other/describe____

1. Frequency of urination: awake hour's ____ times per 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? _______minutes, _______hours, ________not at all
3. The usual amount of urine passed is: ___small ___ medium___ large.
4. Frequency of bowel movements ____ times per day, _______times per week, or ___________.
5. 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.

6. 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

Skip questions if no leakage/incontinence

7. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per month
___ Only with physical exertion/cough

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

9. 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

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PELVIC FOOR CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and 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 evaluation, treatment and options available for my condition.

I also 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 sensors for muscle biofeedback.

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

Release of medical records:

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

Cooperation with treatment:

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty 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.

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 and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of Elite Physical Therapy.

Date______________________________ Patient Name: ____
(Please Print)

____________________________________ ____

Patient Signature Signature of Parent or Guardian (If applicable)

____

Witness Signature

PAYMENT POLICY

elite PHYSICAL THERAPY

Thank you for choosing us as your physical therapy provider. Our goal is to provide high quality, thorough, effective treatment and care to each and every patient. In return, we ask each patient to accept responsibility for paying the fees for his or her treatment. Please read through this short policy statement and sign your name to indicate your acceptance. At the time you receive treatment, please pay the portion of your fees which is not covered by insurance. Payment may be made by check, Visa, MasterCard, debit card (with Visa or MasterCard logo), or in cash.

We will verify your insurance benefits before your first appointment. However, verification of eligibility is not a guarantee of payment. I understand that I am responsible for any fees not covered by my insurance. I also understand that it is my responsibility to check my insurance policy to be aware of any limitations (such as visit limit) or exclusions.

We'll make a good faith effort to obtain payment from your insurer according to the information you give us, and in turn we'll expect you to pay whatever remaining balance exists when sixty days have gone by since your treatment.

If payment is not made on each appointment or if a remaining balance is not paid after being presented with a bill, we may decline to schedule additional treatments until you have paid for the services already provided.

Missed appointments are a problem for us. If you realize that you won't be able to keep your appointment, please let us know as soon as possible. If you miss any of your appointments without notifying us at least 24 hours ahead, we will charge you $50.00 missed appointment fee.

Thank you for the time you've taken to read through this sheet. We ask that you sign your name below to acknowledge our payment policy.

Sign: ____ Date: ____________________

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I understand that **Elite Physical Therapy** (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records, or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- Make decision about and plan for my care and treatment;
- Refer to/or consult and coordinate with other health care providers in the course of my treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or other who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business function that support the clinic's ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will bee posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of the clinic's Notice of Privacy Practices.

Patient Signature: ____ Date:___________________

Patient Representative Signature: ____ Date:___________________

Description of Representative's Authority: ____

FOR OFFICE USE ONLY

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

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (please specify)____