FAMILY Physical Therapy FOUNTAIN POINT

## PATIENT INFORMATION

**PATIENT NAME** (first & last): ______________________________

**DATE OF BIRTH:** ____________________ **SSN:** ____________________

**HOME ADDRESS:** ______________________________
STREET CITY STATE ZIPCODE

**MAILING ADDRESS** (skip if same as above): ______________________________

**HOME PHONE NUMBER:** ____________________ **CELL PHONE NUMBER:** ____________________

**EMAIL ADDRESS:** ______________________________

**PLEASE SELECT:** MARRIED_____ SINGLE _____ STUDENT: _____ OTHER: _______

**DO YOU WANT APPOINTMENT REMINDERS**? IF YES, SELECT ONE - **TEXT**____ **CALL**____ **EMAIL**____

**EMERGENCY CONTACT NAME:** ____________________ **PHONE:** ____________________

**RELATIONSHIP TO PATIENT**: ____________________

**DO YOU HAVE INSURANCE? YES**_____ **NO** _____

**PRIMARY INSURANCE NAME:** ______________________________

**SECONDARY INSURANCE NAME:** ______________________________

**FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT:** (skip if same as above)

**NAME** (first & last): ____________________ **DATE OF BIRTH:** ____________________

**MAILING ADDRESS:** ______________________________

**PHONE NUMBER:** ____________________ **SSN:** ____________________

**WORKER'S COMPENSATION? YES**_____ **NO** _____ DATE OF INJURY: ____________________

EMPLOYER NAME & NUMBER: ____________________ CLAIM NUMBER: ____________________
ADJUSTER NAME & NUMBER: ______________________________

**MOTOR VEHICLE ACCIDENT? YES** _____ **NO** _____ DATE OF INJURY/ACCIDENT: ____________________

AT FAULT _____ NOT AT FAULT _____ CLAIM NUMBER: ____________________
INSURANCE COMPANY NAME & ADDRESS: ______________________________
ADJUSTER NAME & NUMBER: ______________________________

______________________________ ____________________
**Patient or Parent/Legal Guardian Signature** **Date**

FAMILY Physical Therapy
FOUNTAIN POINT

## PERSONAL INFORMATION

NAME: ______________________________ DOB: _________________

Describe the current problem that brought you here: ______________________________________

_______________________________________________________________________________

When did your problem first begin? _______ months ago _______ years ago

Was your first episode of the problem related to a specific incident? _____ YES _____ NO

If yes please describe: ______________________________________________________

Since that time the problem is: ______ the same _____ getting worse _____ getting better

What relieves your symptoms? ____________________________________________________

***CURRENT*** Pain Level: _______ ***BEST*** Pain Level: _______ ***WORST*** Pain Level: ______

0 No pain — 1 — 2 — 3 — 4 — 5 Moderate pain — 6 — 7 — 8 — 9 — 10 Worst possible pain

**MARK AREAS OF DISCOMFORT:**

FRONT BACK

**TYPE OF PAIN** (check all that apply)

- ☐ ACHING
- ☐ BURNING
- ☐ CONSTANT
- ☐ DULL
- ☐ NUMBNESS
- ☐ SHARP
- ☐ STABBING

Activities / events that cause or aggravate your symptoms: (check all that apply)

- ☐ Changing positions (sit to stand)
- ☐ Cold weather
- ☐ Coughing / sneezing / straining
- ☐ Laughing / yelling
- ☐ Lifting / bending over
- ☐ Light activity
- ☐ No activity affects the problem
- ☐ Sexual activity
- ☐ Sitting more than ____ minutes
- ☐ Standing more than _____ minutes
- ☐ Triggers (running water/keys in door)
- ☐ Vigorous activity
- ☐ Walking more than ____ minutes
- ☐ With nervousness/anxiety
- ☐ Other: ______________________________

FAMILY Physical Therapy FOUNTAIN POINT

## PERSONAL INFORMATION

Since onset of your current symptoms have you had:

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

Other: ______________________________

Describe how your lifestyle/quality of life has been altered/changed because of this problem:

Social activity: ______________________________

Diet / fluid intake: ______________________________

Physical activity: ______________________________

Work: ______________________________

Other: ______________________________

Rate the severity of the problem from 0–10 with 0 being no problem and 10 being the worst: ________

What are your treatment goals? ______________________________

Date of last physical exam: ________________

Tests performed during exam: ______________________________

General health (circle one): EXCELLENT GOOD AVERAGE FAIR POOR

Occupation: ________________ Hours/week: ________ On disability or leave? __________

Current level of stress (circle one): HIGH MODERATE LOW

Activity/Exercise (circle one): None 1-2 days/week 3-4 days/week 5+ days/week

Medications/Vitamins: ______________________________

______________________________

______________________________

Surgical History:

- Y / N Abdominal organs
- Y / N Bladder surgery
- Y / N Bone / Joint surgery
- Y / N Back / Spine surgery
- Y / N Brain surgery
- Y / N Female organs

Other / describe: ______________________________

______________________________

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## CHECK ALL THAT APPLY TO CURRENT OR PAST MEDICAL HISTORY:

- ☐ ALCOHOLISM / DRUG PROBLEM
- ☐ ALLERGIES (FOOD / SEASONAL)
- ☐ ANOREXIA / BULIMIA
- ☐ ASTHMA / BRONCHITIS
- ☐ ARTHRITIS
- ☐ BACK PAIN
- ☐ BALANCE / HISTORY OF FALLS
- ☐ BLOOD CLOT
- ☐ BOWEL / BLADDER DIFFICULTY
- ☐ BRUISE / BLEED EASILY
- ☐ CANCER / CHEMOTHERAPY
- ☐ CONSTIPATION
- ☐ COPD
- ☐ DEPRESSION
- ☐ DIABETES
  - TYPE: ________
- ☐ DIZZINESS / FAINTING
- ☐ EPILEPSY / SEIZURES
- ☐ FATIGUE
- ☐ FIBROMYALGIA
- ☐ FOOT/ANKLE PAIN
- ☐ HAND/ELBOW PAIN
- ☐ HEADACHES / MIGRAINES
- ☐ HEART ATTACK
- ☐ HEART DISEASE
  - TYPE: ________ ____________
- ☐ HEPATITIS / HIV / AIDS
- ☐ HIGH BLOOD PRESSURE
- ☐ HERNIA
- ☐ IRRITABLE BOWL SYNDROME
- ☐ INCONTINENCE
- ☐ INFECTIOUS DISEASE
- ☐ JOINT REPLACEMENT
  - TYPE: ________ ____________
- ☐ KIDNEY DISEASE
- ☐ KNEE PAIN
- ☐ LATEX ALLERGY / SENSITIVITY
- ☐ LOW BACK PAIN
- ☐ LOW BLOOD PRESSURE
- ☐ MULTIPLE SCLEROSIS
- ☐ NAUSEA
- ☐ NECK PAIN
- ☐ NUMBNESS / TINGLING
- ☐ OSTEOPOROSIS
- ☐ PARKINSON'S DISEASE
- ☐ PELVIC PAIN
- ☐ PHYSICAL / SEXUAL ABUSE
- ☐ SACROILIAC / TAILBONE PAIN
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ SHORTNESS OF BREATH
- ☐ SHOULDER PAIN
- ☐ SLEEPING DIFFICULTY
- ☐ SMOKING HISTORY
- ☐ SPEECH DIFFICULTY
- ☐ STROKE
- ☐ SWALLOWING DIFFICULTY
- ☐ SWELLING OF LIMBS
- ☐ THYROID DISEASE
- ☐ VISION / HEARING DIFFICULTY
- ☐ WEAKNESS
- ☐ WEIGHT LOSS
- ☐ OTHER: ________________ ________________ ________________

OB/GYN History:

**Y / N** C-Sections # _____

**Y / N** Difficult childbirths # _____

**Y / N** Episiotomy # _____

**Y / N** Menopause – when? __________

**Y / N** Painful vaginal penetration

**Y / N** Painful periods

**Y / N** Pelvic pain

**Y / N** Prolapse or organ falling out

**Y / N** Vaginal deliveries # _____

**Y / N** Vaginal dryness

FAMILY Physical Therapy FOUNTAIN POINT

## PELVIC SYMPTOM QUESTIONNAIRE

Bladder / Bowel habits or problems:

**Y / N** Blood in urine
**Y / N** Constipation / Straining
**Y / N** Constant urine leaking
**Y / N** Difficulty initiating urine stream
**Y / N** Difficulty stopping urine stream
**Y / N** Difficulty feeling bladder urge/fullness
**Y / N** Difficulty emptying bladder
**Y / N** Difficulty feeling bowel urge/fullness
**Y / N** Difficulty holding back gas/feces
**Y / N** Dribbling after urination
**Y / N** Painful urination
**Y / N** Recurrent bladder infections
**Y / N** Urinary intermittent / slow stream

Other/describe: ______________________________

1. Frequency of urination? Awake hours _____ times per day. Sleep hours _____ times per night.
2. When you have a normal urge to urinate, how long can you delay before going 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 __________ other
5. When you have an urge for a bowel movement, how long can you delay before going to the toilet?

   _____ minutes _____ hours _____ not at all
6. If constipation is present, please describe management techniques: ______________________

   ______________________________
7. Average fluid intake (one glass is 8oz or 1 cup): ______ glasses per day

   of this total, how many glasses are caffeinated? _____ glasses per day
8. Do you have the feeling of your organs "falling out" / prolapse or pelvic heaviness / pressure?

   _____ none present

   _____ times per month (specify below if related to activity or your period)

   _____ with standing for _____ minutes or _____ hours

   _____ with exertion or straining

   Other/describe: ______________________________

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## PELVIC SYMPTOM QUESTIONNAIRE (cont.)

**9. A:** Bladder leakage (number of episodes)

___ no leakage

___ times per day

___ times per week

___ times per month

___ only with physical exertion/coughing

**B:** Bowel leakage (number of episodes)

___ no leakage

___ times per day

___ times per week

___ times per month

___ only with physical exertion/coughing

**10. A:** How much urine do you leak?

___ no leakage

___ just a few drops

___ wets underwear

___ wets the floor

___ only with physical exertion/coughing

**B:** How much stool do you lose?

___ no leakage

___ stool staining

___ small amount in underwear

___ complete emptying

___ only with physical exertion/coughing

**11.** What form of protection do you wear? (Choose ONE)

_____ none

_____ minimal protection (tissue paper / paper towel)

_____ moderate protection (absorbent product / maxi pad)

_____ maximum protection (specialty product / diaper)

Other/describe: ______________________________

**12.** How many pads or protection changes are required in 24 hours? _____ number of pads

______________________________ ______________________________

**Patient or Parent/Legal Guardian Signature** **Date**

# NOTICE OF INFORMATION PRIVACY PRACTICES

## 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.

Family Physical Therapy and Sports Center, P.C. is required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information. This notice fulfills the "Notice" requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at Family Physical Therapy and Sports Center, P.C., please call us at 308-236-5884 or 308-698-2820.

Acknowledgement of receipt of this notice: I have been informed of the Privacy Policies of Family Physical Therapy and Sports Center, P.C.

__________________________________ ____________________

**Patient or Parent/Legal Guardian Signature** **Date**

## RELEASE OF PERSONAL HEALTH INFORMATION:

IF YOU WISH FOR ANYONE OTHER THAN YOURSELF TO HAVE ACCESS TO YOUR MEDICAL OR FINANCIAL RECORDS, PLEASE LIST THOSE NAMES AND THEIR RELATIONSHIP TO YOU BELOW:

| RELEASE TO: | | RELATIONSHIP: | |
|---|---|---|---|
| | ________________ | | ________________ |
| | ________________ | | ________________ |
| | ________________ | | ________________ |
| | ________________ | | ________________ |

## AUTHORIZATION FOR RELEASE OF INFORMATION AND CONSENT TO TREAT

The undersigned hereby authorizes ***FAMILY PHYSICAL THERAPY AND SPORTS CENTER*** to furnish from my medical record requested information or excerpts to the referring physicians, if any, and to Medicare, Medicaid, or any insurance company for the purpose of processing claims and to obtain payment of the account for services provided to the patient. By signing, this authorization the patient, parent or legal guardian of the patient hereby gives to medical treatment.

## MEDICARE RELEASE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any authorized benefits be made on my behalf.

## FINANCIAL AGREEMENT

The undersigned hereby agrees that, in consideration of the services to be rendered to the patient, to pay ***FAMILY PHYSICAL THERAPY AND SPORTS CENTER*** in accordance with the regular rate and the offices payment policy. Some insurance companies do not pay for hot/cold packs. These are billable services and due by the patient. **A LATE FEE WILL BE CHARGED TO ALL OVERDUE ACCOUNT BALANCES AFTER 60 DAYS.**

## WORKER'S COMPENSATION

**PLEASE NOTIFY OFFICE STAFF AT CHECK-IN IF THIS IS A WORKER'S COMPENSATION INJURY**

Any patient claiming worker's compensation must bring notice of injury from their employer before it will be turned into worker's compensation insurance. Otherwise, all billing will be submitted to personal medical insurance.

## ATTENDANCE POLICY

If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be cancelled. Please give 24 HOUR notice if you need to cancel your appointment. **Three consecutive no-shows** will result in the cancellation of all remaining scheduled appointments. Repeated failure to comply with this **ATTENDANCE POLICY** will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

This undersigned certifies that he/she has read the forgoing, and is the patient or duly authorized by or on behalf of the patient to execute the above and accepts its terms.

______________________________ ______________________

**Patient or Parent/Legal Guardian Signature** **Date**