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PHYSICAL THERAPY

PATIENT INFORMATION:

Patient Name: _____ **Gender:** Male or Female

Address: _____
Street Town/City State Zip Code

Date of Birth: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____

Employer: _____ **Occupation:** _____

Referring Physician: _____ **Phone Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

How did you hear about us?: **Google** **Facebook** **Newspaper** **MD Referral** **Word of Mouth** **Other**
(Please circle your choice)

INSURANCE INFORMATION:

Primary Insurance: _____ **Phone Number:** _____

Policy Number: _____ **Group Number:** _____

Subscriber: _____ **Date of Birth:** _____ **Relationship:** _____

Secondary Insurance: _____ **Phone Number:** _____

Policy Number: _____ **Group Number:** _____

Subscriber: _____ **Date of Birth:** _____ **Relationship:** _____

PATIENT MEDICAL HISTORY

Describe the current problem that brought you here: _____

_____

When did your problem begin? (months, years): _____

Was your episode of them problem related to a specific incident? YES / NO

Please describe and specify date: _____

Since that time is your condition (circle one):

a. Staying the same b. Getting worse c. Getting better

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Is pain present? YES / NO **Describe the pain: (Burning, ache etc.)** _____

Rate your Pain Level below:

Please indicate your WORST pain level on the scale below:

NO PAIN 1 2 3 4 5 6 7 8 9 10

Please indicate your CURRENT pain level on the scale below:

NO PAIN 1 2 3 4 5 6 7 8 9 10

Please indicate your BEST pain level on the scale below:

NO PAIN 1 2 3 4 5 6 7 8 9 10

Describe Previous Treatments/Exercises: _____

Activities/events that cause or aggrevate your symptoms. Check/Circle all that apply.

_____ Sitting greater than____ min

_____ Walking greater than_____ min

_____ Standing greater than_____ min

_____ Changing positions (sit to stand, laying down to sitting up

_____ Light Activity

_____ Vigorous activity/exercise (run, weigh lift, jumping)

_____ Sexual Activity

_____ With cough/sneeze/straining

_____ With laughing/yelling

_____ With lifting/bending

_____ With cold weather

_____ With triggers– running water/key in the door

_____ With nervousness/anxiety

_____ Other, please list

_____

_____ No activity affects the problem

What relives your symptoms? _____

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

Social Activity: _____ **Physical Activity:** _____

Diet/Fluid Intake: _____ **Work (specify):** _____

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What are your treatment goals/concerns _____

Since the onset of your currents symptoms, have you had (check all that apply):

_____ Fevers/ Chills
_____ Unexplained weight changes
_____ Dizziness or fainting
_____ Changes in bowel or bladder functions
_____ Other (please describe): _____
_____ Malaise (unexplained tiredness)
_____ Unexplained muscle weakness
_____ Night pain/sweats
_____ Numbness/tinging

Date of last physical exam: _____

Tests performed: _____

General Health: Excellent Good Average Fair Poor

Mental Health: Current Level of Stress: High Medium Low Current psych therapy? Yes/No

Activity/Exercise: None 1–2 days/week 3–4 days/week 5–7 days/week

Have you ever had any of the following conditions or diagnoses? Check all that apply

_____ Alcoholism/Drug Use
_____ Anemia
_____ Anorexia/Bulimia
_____ Arthritic Conditions
_____ Bone Fracture
_____ Cancer
_____ Childhood Bladder Problems
_____ Chronic Fatigue Syndrome
_____ Depression
_____ Diabetes
_____ Emphysema/Chronic Bronchitis
_____ Epilepsy/Seizures
_____ Fibromyalgia
_____ Headaches
_____ Head Injuries
_____ Heart Problems
_____ Hepatitis
_____ HIV/AIDS
_____ Hypothyroid/Hyperthyroid
_____ Irritable Bowel Syndrome
_____ Joint Replacement
_____ Kidney Disease
_____ Latex Sensitivity
_____ Low Back/SI/Tailbone Pain
_____ Multiple Sclerosis
_____ Osteoporosis
_____ Pelvic Pain
_____ Physical or Sexual Abuse
_____ Rheumatoid Arthritis
_____ Sexual Activity
_____ Smoking History
_____ Sports Injuries
_____ Stroke
_____ Vision Problems

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List Current Medications & Allergies (or provide a copy): _____

_____

PAST SURGICAL HISTORY

Type of Surgery: _____ Date: _____

Type of Surgery: _____ Date: _____

_____

OB/GYN History:

Childbirth Vaginal Deliveries # _____

Episiotomy # _____

C–Section # _____

Prolapse or organ falling out: YES / NO

Pelvic Pain: YES / NO

Vaginal Dryness: YES / NO

Painful Periods: YES / NO

Menopause: YES / NO Date: _____

Painful Vaginal Penetration: YES / NO

_____

Bladder/BowelHabits/ Problems

Please check any condition you currently have OR have ever had in the past. Please explain when necessary.

_____ Trouble initiating urine stream

_____ Urinary intermittent/slow stream

_____ Trouble emptying bladder

_____ Difficulty stopping the urine stream

_____ Trouble emptying bladder completely

_____ Straining or pushing to empty bladder

_____ Dribbling after urination

_____ Constant urine leakage

_____ Other _____

_____ Blood in urine

_____ Painful urination

_____ Trouble feeling bladder urge/fullness

_____ Current laxative use

_____ Trouble feeling bowel/urge/fullness

_____ Constipation/straining

_____ Trouble holding back gas/feces

_____ Recurrent bladder infections

_____

Pelvic Symptom Questionaire

Frequency of urination:

Awake hours _____ /per day

Sleep hours _____/per day

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 ll

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Pelvic Symptom Questionaire Continued

The usual amount of urine passed is:

_____ Small _____ Medium _____ Large

Frequency of bowel movements _____ times per day _____ times per week

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

If consitipation is present, describe management techniques: _____

_____

Average Fluid Intake (1 cup is 8 oz) Ounces _____/per day

Of this total, how many of the beverages are caffienated?_____

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

_____ None Present
_____ (Blank) times per month
_____ With standing for _____ minutes or _____ Hours
_____ With exertion or straining
_____ Other: _____

Skip questions if no leakage orincontinence

Bladder leakage – number of episodes: _____ No Leakage

_____ times per day _____ times per week _____ times per month _____Only with exertion/cough

Bowel leakage – number of episodes: _____ No Leakage

_____ times per day _____ times per week _____ times per month _____Only with exertion/cough

On average, how much urine do you leak? _____ No Leakage

_____ just a few drops _____ Wets underwear _____ Wets outerwear _____Wets Floor

How much stool do you lose? _____ No Leakage

_____ just a few drops _____ Wets underwear _____ Wets outerwear _____Wets Floor

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

_____ None _____ Minimal Protection _____ Moderate Protection _____Maximum Protection

On average, how many pads/protection changes are required within 24 hours? _____

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POLICY DISCLOSURES

HIPAA STATEMENT

I understand that Concierge Physical Therapy, Inc. will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. *I have received and read the HIPAA statement provided.*

Patient Signature: _____
Parent/Guardian Signature
(if patient in under 18) _____

WAIVER OF RELEASE OF LIABILITY

In agreeing to receive care provided by Concierge Physical Therapy, Inc. ("Concierge Physical Therapy") and to use the facilities provided therefore by Concierge Physical Therapy at 64 Worcester Providence Turnpike in Sutton, MA 01590 and 307 Grafton Street Shrewsbury, MA 01545 I agree as follows: I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Concierge Physical Therapy and the physical therapy activities and equipment that I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Concierge Physical Therapy the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of representatives or employees of Concierge Physical Therapy, or by another person. I on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Concierge Physical Therapy, Inc., and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Concierge Physical Therapy. I have read the above waiver & release and by signing it agree to the terms therin. It is my intention to exempt and relieve Concierge Physical Therapy from liability for personal injury, property damage and wrongful death caused by negligence or any other cause.

Patient Signature: _____
Parent/Guardian Signature
(if patient in under 18) _____

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POLICY DISCLOSURES

ATTENDANCE POLICY

We strive to provide you with the best, personalized care available. To make this possible we adhere to a set of very important policies.

24-hour Cancellation Notice: If you wish to change or cancel your appointment we require a minimum of 24-hour advance notice. Anything less than that will result in a **$75.00 fee** applied to your account. We charge **$75.00** not to make money, but to act as a deterrent from making last minute changes. Please be courteous and responsible. Thank you.
No Shows: We understand things happen. If you are unable to keep an appointment please call and let us know. Simply not showing up will result in the loss of all scheduled future appointments. New appointments will be allowed on a "first-come, first-serve basis". **ALL NO SHOWS WILL BE CHARGED A FEE OF $100.00.**

I have carefully read and agree to all of the above policies. In the event such policies are broken, I agree to the consequences set forth. Please sign that you have read these policies:

Patient Signature: _____
Parent/Guardian Signature
(if patient in under 18) _____

AN IMPORTANT MESSAGE REGARDING PAYMENT FOR THERAPY SERVICES

We strongly recommend that you contact your insurance company to verify the benefits we have been quoted below. Be certain to tell your insurance company that you will be attending a stand alone outpatient facility as this may impact your benefit. The information listed below shows what your insurance company currently has on file. My signature below acknowledges that I have discussed this information with staff and I understand it is not a guarantee of benefits or insurance coverage for my care. For any reason should my insurance deny, I understand that I am responsible for payment in full. Deductible and Coinsurance payments are an estimate. You may be responsible for more than quoted below. **I understand my card must be on file and payments are due at the time of service**.

DEDUCTIBLE:_____ **AMOUNT MET:**_____
COINSURANCE: _____
COPAY: _____
VISIT LIMIT: _____ **VISIT REMAINING:**_____
TODAY'S COST:_____ **FOLLOW-UP VISIT COST:** _____

Patient Signature: _____
Parent/Guardian Signature
(if patient in under 18) _____