HEALTHY CORE PHYSICAL
THERAPY & WELLNESS
Specialized Pelvic Rehabilitation

PATIENT INTAKE FORM

Client Information

Today's Date:_____

First Name: _____ **Last Name**_____ **MI**___

Address_____ **Apt #**_____

City_____ **State**_____ **Zip Code**_____

Home phone:_____ **Work phone**_____

Employer: _____ **Occupation** _____

Date of Birth_____

****Please provide a valid Mobile number and Email so we may send you follow-up appointment confirmations****

Mobile # _____ **Email**_____

Emergency contact name_____

Emergency contact Phone _____

Emergency contact relationship (circle choice) Spouse Child Parent Friend Other

Who can we thank for referring you to our practice? _____

Physician Information

Primary Care Physician _____

Address_____

Phone _____ **Fax** _____

Referring Physician_____

Address _____

Phone _____ **Fax** _____

Please describe the current problem/issue that brought you here_____

_____

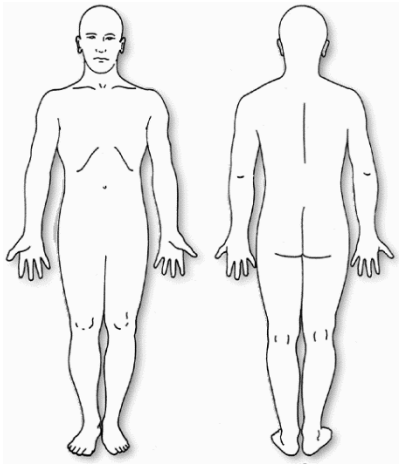
When did your problem first begin? _____

Since that time, is it: _____ staying the same _____ getting worse _____ getting better

If pain is present, rate pain on a 0-10 scale, 0= no pain, 10 being the worst_____

Please mark where and type of pain using the codes listed below:

N=Numbness
P=pain
T=Tingling
A=Ache
S= Soreness
ST=Stiffness



Check the words that describe your pain:

___ Aching	___ Dull	___Constant	___Intermittent
___Hot	___Tearing	__Suffocating	___Unbearable
___Burning	___Tiring	___ Sickening	___Discomforting
___Scalding	___Exhausting	___Annoying	____Pressure
___Searing	___Frightful	___Troublesome	____ Heaviness
___Sharp	___Punishing	___Miserable	Other_____
___Cutting	___Grueling	___Intense	_____
			_____

Check ALL the activities that cause or increase your symptoms:

___Sitting greater than _____ minutes

___Walking greater than_____ minutes

___Standing greater than _____ minutes

___Changing positions (ex. sit to stand)

___Light activity (ex. light housework)

____Vigorous activity (ex. exercise, sports)

____ Sexual activity

____Other, please list_____

____ With cough/sneeze/laugh/yelling

____ With laughing/yelling

____ With lifting/bending

____ With cold weather

____ With nervousness/anxiety

____ With triggers (key in door, seeing toilet)

____ No activity affects the problem

What relieves your symptoms?

___Heating pad	___Medication	___Cream _____
___Ice pack	___Not using tampons	___ Urinating/bowel movement
___Resting in bed	___Not wearing tight clothes	Other_____
___Resting in Chair	___Abstaining from sex	_____
		_____

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

Ex: Physical activity, work, household activities, social activities, diet/fluid intake,

_____

_____

_____

Other _____

_____

Rate the severity of this problem from 0-10 with 0=no problem and 10=the worst _____

What are <u>your</u> treatment goals/concerns?_____

_____

<u>Since the onset of your current symptoms, have you had:</u>

Y/N	Fever/chills	Y/N	Malaise(unexplained tiredness)
Y/N	Unexplained weigh change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Numbness/tingling	Y/N	Change in bowel or bladder function

Y/N Other/describe _____

Date of last physical exam _____ **Tests performed** _____

_____

_____

General health: Excellent Good Average Fair Poor

Activity/exercise: None 1-2 days/week 3-4 days/week 5+days/week

Type of exercise/activity: _____

Mental Health: Current level of stress High Medium Low

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

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	Acid Reflux/Belching	Hepatitis
Anorexia/Bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone fracture	Physical or sexual abuse
Vision/Eye problems	Sports injuries	Raynaud's (cold hands & feet)
Hearing loss/problems	TMJ/neck pain	Pelvic pain

Other, describe _____

_____

_____

Surgical History (i.e. spine, hysterectomy, bladder/prostate etc.): List surgery and date:

_____

_____

_____

_____

OB/GYN history (females only)

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/genital pain
Y/N	Other, describe_____		

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic/genital pain, location _____		
Y/N	Other, describe _____		

Please list all current medications and dosages, if known, or attach list_____

_____

_____

_____

_____

_____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Symptoms

Y/N	Trouble initiating urine stream	Y/N	Blood in stool/feces
Y/N	Urinary intermittent /slow stream	Y/N	Painful bowel movements (BM)
Y/N	Strain or push to empty bladder	Y/N	Trouble feeling bowel urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Seepage/loss of BM without awareness
Y/N	Trouble emptying bladder completely	Y/N	Trouble controlling bowel urge
Y/N	Blood in urine	Y/N	Trouble holding back gas/feces
Y/N	Dribbling after urination	Y/N	Trouble emptying bowel completely
Y/N	Constant urine leakage	Y/N	Need to support/touch to complete BM
Y/N	Trouble feeling bladder urge/fullness	Y/N	Staining of underwear after BM
Y/N	Recurrent bladder infections	Y/N	Constipation/straining _____% of time
Y/N	Painful urination	Y/N	Current laxative use -type _____
Y/N	Other/describe _____		

Describe typical position for emptying: _____

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. The bowel movements typically are: ___ watery, ___ loose, ___formed, ___ pellets, _____other
6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the
_____minutes, _____hours, _____not at all.
7. If constipation is present describe management techniques _____
8. 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.
9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your menstrual period)
___With standing for _____ minutes or _____hours.
___With exertion or straining
___Other_____

10a. Bladder leakage - number of episodes	10b. Bowel leakage - number of episodes
___ No leakage	___ No leakage
___ Times per day	___ Times per day
___ Times per week	___ Times per week
___ Times per month	___ Times per month
___ Only with physical exertion/cough	___ Only with exertion/strong urge
11a. On average, how much urine do you leak?	11b. How much stool do you lose?
___ No leakage	___ No leakage
___ Just a few drops	___ Stool staining
___ Wets underwear	___ Small amount in underwear
___ Wets outerwear	___ Complete emptying
___ Wets the floor	___ Other _____

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

___None
___Minimal protection (tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxi pad)
___Maximum protection (specialty product/diaper)
___Other _____

On average, how many pad/protection changes are required in 24 hours? _____# of pads

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

_____Cooperation with treatment:
I understand that in order for physical 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 physical therapy 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 or fail to come to a scheduled appointment, I will pay a cancellation fee of $50.00.

_____No warranty: I understand that Healthy Core Physical Therapy & Wellness, LLC and Kelly McArthur, DPT cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that Kelly McArthur, DPT will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

<u>Informed consent for treatment</u>:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been 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 treatment and options available for my condition.

_____Potential risks: I understand 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 24 hours, I agree to contact my physical 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. Please list.

_____

_____

Financial and insurance responsibilities:
_____ I agree to pay for my evaluation and treatments at the time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will provide me with a receipt that is my responsibility to submit to my insurance company. If I am a Medicare beneficiary, I understand that it is the responsibility of my therapist to submit a claim to Medicare for reimbursement for treatment rendered.

I have read the above information and I consent to physical therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

_____ _____

Print Name Date

Patient's signature (if minor, parent or legal guardian must sign) Therapist Signature / Date

PATIENT NOTICE OF PRIVACY

Introduction: At Healthy Core Physical Therapy & Wellness, LLC, we are committed to treating and protecting your medical information. The creation of a medical record detailing the care and services you receive helps us provide you with quality health care. This Patient Notice of Privacy describes the health information we collect and shows the ways in which your medical information can be used. You must sign and date the Notice of Privacy statement before you begin treatment

Understanding your Health Information: Each time you visit Healthy Core Physical Therapy & Wellness, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan of care for your treatment. This information is often referred to as your health or medical record.

Your Rights: Although your health record is the physical property of Healthy Core Physical Therapy & Wellness, the information belongs to you. You have the right to:

- Obtain a copy of the notice of privacy practices upon request
- Inspect and copy your health record
- Make changes in your health record
- Make a list of who your medical record was shared with
- Request communication of your medical record in certain places (for example, you may want us to call you at work instead of home)
- Request a restriction on certain uses and sharing of your information
- Revoke your permission for use or sharing of your medical record except to the extent that action has already been taken

Our Responsibilities: Healthy Core Physical Therapy & Wellness is required to:

- Maintain the privacy of your medical records
- Provide you with this notice as to our legal duties and privacy practices with respect to your medical records we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a request restriction
- Accommodate reasonable requests you may have to communicate your medical records by alternative locations

We reserve the right to change our practices and to make the new provisions effective for all medical records we maintain.

We will not use or share your medical record without permission, except as described in this notice. We will also discontinue the use of the Patient Notice of Privacy Practices and share your medical record after we have received notice in writing that you have revoked your permission.

Use and Sharing of Health Information for Treatment, Payment, and Health

Operations

The law allows us to use your medical records without your permission for treatment, payment, and business operations. The following are some examples: patient billing, third party billing, quality of care and improved services, other specialty care, caregiver/ family member notification/communication, research, organ and tissue donation, marketing, fundraising, Food and Drug Administration (FDA), Workers Compensation, law enforcement, and public health. Federal law makes provision for your medical records to be released to an appropriate health over sight agency, public health authority or attorney, provided that a work force member of business associate believes in good faith that we have engaged in unlawful conduct of have otherwise violate professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

For more information or to report a problem

If you have any questions or requiring additional information, please

contact Healthy Core Physical Therapy & Wellness at 561-685-6229 or email:

healthycorept@gmail.com

I have read the above and agree to the Patient Notice of Privacy:

Signature: _____ Date of Birth: _____

Name (print): _____