restore
PHYSICAL THERAPY

GENERAL INFORMATION:

First Name: ______________________________

Middle Name: ______________________________

Last Name: ______________________________

Preferred Name: ______________________________

SSN: ________ - _______ - _________ **(optional)**

Birthdate: _______ / ______ / ________

Gender: Male/Female

Pronouns: He/Him, She/Her, They/Them, Prefer Not to Say

MINOR:

Parent/Guardian Name: ______________________________

Address: ______________________________

Phone: ______________________________

Birthdate: ____________ SSN: ____ - ____ - ____

Employer: ______________________________

CONTACT INFORMATION:

Primary Phone: ____________________ Cell/Home/Work

Secondary Phone: _________________ Cell/Home/Work

Email: ______________________________

Appointment Text Reminder*: ◯

***Note by checking the text reminder box you authorize certain PHI to be disclosed (ie: name, email, appointment information)**

Physical Address: ______________________________

City: _________________ State: ______ Zip: __________

Billing Address: ______________________________

EMERGENCY CONTACT:

Name: ____________________Phone: _______________

Address: ______________________________

Relation: _________________________

REFERRING PHYSICIAN & FACILITY:

____

Date of Surgery (if applicable): _____________________

Do you have a follow-up appointment with the doctor who referred you to physical therapy?

o YES, date of appointment: _____________________

o NO, I am to call the doctor to schedule a follow up

o NO, doctor did not request to see me again

Please complete the following as applicable:

Occupation: ___________ Employer: _______________

Phone: ___________________________

Business address: ________________________

MARITAL STATUS: Single/Married/Widow/Divorced

Spouse Name:____________________________

Employer: _______________Ph: _____________

INSURANCE INFORMATION:

Primary Insurance: ______________________________

ID#: _______________________ Group#: ____________

Insurance Phone: _______________

Claims Address: ______________________________

Secondary Insurance:____________________________

ID#: ________________________ Grp#_____________

Insurance Phone: ________________

Claims Address: ______________________________

◯ **Motor Vehicle Accident** ◯ **Workers' Comp**

If yes, Date of injury: ____________ State: ___________

Claim #: ______________________________

Restore Physical Therapy is committed to providing quality physical therapy at reasonable cost. It is our policy to collect all accounts receivable within 90 days from date of service.

For those patients with insurance coverage, we bill regularly. ***However, the patient is responsible to understand the specifics of their individual insurance coverage.*** **The insurance contract is between the covered individual and the insurance company.** The patient retains ultimate responsibility for financial charges incurred as a result of treatment. Our staff is available for assistance with insurance billing questions.

<u>CONSENT FOR TREATMENT</u>

I hereby consent to such physical therapy procedures as may be rendered by Restore Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Restore Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. A $20.00 fee will be charged for returned checks. Restore Physical Therapy has the authority to disclose medical information for treatment, payment and health operations. Restore Physical Therapy is released from disclosure of the patient's records as provided by this paragraph.

____

Patient or Guardian Signature **Date**

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PHYSICAL THERAPY

PELVIC HEALTH INTAKE

Please describe your main concern:

____

____

When did it begin? ____________ Is it getting: Better | Worse | No Change

Please describe activities that you are unable to do because of this problem:

____

____

Medical History

Do you have / Have you had:	YES	NO
Diabetes		
Osteoarthritis		
Osteoporosis		
Rheumatoid Arthritis		
Headaches		
Cancer		
High Blood Pressure		
Pacemaker		
Heart Disease		
Dizziness/Fainting		
Fevers/Chills		
Weight Changes		
Pelvic Organ Prolapse		
Endometriosis		
Cysts/Fibroids		
Urinary Tract Infections		

Surgeries:	Date:
Hysterectomy	
C-Section	
Gall Bladder	
Prostatectomy	
Appendectomy	
Hernia repair	
Laparoscopy	
Metoidioplasty	
Phalloplasty	
Vaginoplasty	
Mastectomy	
Gender Affirmation Surgery	
Chest reconstruction	
Prolapse Repair	
Other:	

If Applicable:

Have your periods stopped? Yes / No Date of last period: ____________

Do you have an IUD? Yes / No Do/did you have pain with your periods? Yes / No

Are you pregnant? Yes / No Are you attempting to get pregnant? Yes / No

How many times have you been pregnant: ______

How many times have you given birth: ______ Vaginal or C-section

Did you have a tear or episiotomy or assisted birth? ____________

Are you on any type of supplemental hormone therapy? Yes / No

If so, please list:

____

____

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PHYSICAL THERAPY

BLADDER HEALTH INTAKE

	NEVER	SOMETIMES	OFTEN
Do you leak urine when you cough, sneeze, laugh, or when lifting?			
Do you ever have an uncomfortable, strong need to urinate that if you don't reach the toilet you will leak?			
If "yes" to question #2, do you ever leak before you reach the toilet?			
Do you have an urge to urinate when you hear running water?			
Do you have an urge to urinate when your hands are in water?			
Do you ever leak urine during or after sexual intercourse?			
Have you had bladder, urinary or kidney infections?			
Are you troubled by pain or discomfort when you urinate?			
Have you had blood in your urine?			
Do you find it hard to begin to urinate?			
Do you have a slow urine stream?			
Do you strain to pass your urine?			
After you urinate, do you have dribbling or a feeling that your bladder is still full?			
Do you have burning when you urinate?			

Please try to give actual numbers for the following questions:

How many times do you urinate during the day? ____

How many times do you urinate after you go to bed? ___________________________________

How often do you leak urine? ____

Do you wear protection? **(Circle one)**: None Pantiliner Maxi Pad Diaper/Serenity

How many pads do you use in a day? ____

Leakage equals **(Circle one)**: Small (less than 1/2 cup) Large (more than 1/2 cup)

How much warning time do you have to get to the toilet? Seconds or Minutes _____________

Fluid Intake: (Includes water and other beverages):

8 oz glasses per day (circle one below): 9+ 6 - 8 3 - 5 1 - 2

Caffeinated drinks per day (circle one): 9 + 6 - 8 3 - 5 1 - 2

Type of caffeinated beverage(s): ____

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SEXUAL HEALTH INTAKE

Are you currently sexually active? Yes No

Do you experience pain or other problems with sexual activity? Yes No
If yes, please describe: (e.g., pain with initial penetration, painful to touch, pain with thrusting)

____
____
____
____

Do you have increased pelvic pain with other activities? Yes No
If yes, please describe: (e.g., wearing tight clothes, sitting, pain with gynecology exam)

____
____
____
____

Does the pelvic pain ever feel like it travels? ______________________________
If yes please describe: ______________________________
____
____

BOWEL HEALTH INTAKE

Even if you are not having bowel complaints, please fill out the following section as bowel health can relate to bladder or sexual health complaints

Frequency of bowel movements: (Circle one)
2+ times per day 1 time per day Every other day Once every 4-6 days Weekly

Do you strain to pass your bowels? Yes / No / Sometimes

Do you have pain with bowel movements? Yes / No / Sometimes

Do you have anal fissures? Yes / No

Do you get hemorrhoids? Yes / No **Do you currently have hemorrhoids?** Yes / No

Do you have fecal urgency? Yes / No / Sometimes **Do you have fecal incontinence?** Yes / No

Do you still feel full after having a bowel movement? Yes / No

Do you ever have to use your hands to help pass a bowel movement? Yes / No

Do you use enemas? Yes / No

If yes, when was the last time you used one ____________________

Do you take fiber supplements? Yes / No

If yes, please let us know which ones you use: ______________________________

Medications:

____

____

____

____

____

____

____

Supplements:

____

____

____

Allergies:

____

____

____

Is there anything else you would like us to know?

____

____

____

____

____

APPOINTMENTS

Your Copay or Coinsurance amount is due at the beginning of your appointment. Please notify the front office of any address, phone number or insurance changes.

LATE ARRIVALS

In order to remain on schedule for all our patients, we may shorten your appointment time if you are late to your appointment. Your Copay or Coinsurance amount will still be due.

As a courtesy to others, if you arrive more than 10 minutes late to your scheduled appointment, you will be asked to reschedule and this will incur a $50 late cancellation fee.

LESS THAN 24-HR CANCELLATION / NO SHOW

We do charge the patient, not the insurance, a **$50 fee** for cancellations less than 24-hour notice and/or if you do not show for your appointment. After 2 no shows, all future appointments will be canceled. After 2 late cancelations, we will move to a "one appointment at a time" basis. You will be discharged as a patient if you have 3 cancellations less than 24-hours and/or 2 no show appointments.

HIPAA NOTIFICATION

I acknowledge that I have been informed and notified of the whereabouts of Restore Physical Therapy's notice of information practices (how medical information regarding myself may be used and disclosed and how I can get access to this information).

By signing this, I agree to and understand the policies Restore has outlined above.

____

Patient or Guardian Signature Date