|  |
| --- |
| Patient Information (Please Print) |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| First Name |  | MI |  | Last Name |  | DOB |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Address |  | City |  | State |  | Zip |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Phone (     ) |  | Email: | | |
| How do you want to receive appointment reminders? | | | Select 1:  Text  Phone Call  Email |  | |

Sex (*required for insurance purposes*):  Male  Female

Gender if different from sex (*optiona*l):  Transgender  Gender Fluid  Non-Binary Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pronoun Preference (*optional*):  he/ him/ his  she/ her/ hers  they/ them/ theirs  Other \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Who may we thank for referring you? | Please Indicate Whom |  |

|  |
| --- |
| Emergency Contact |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | Phone (     ) |  | Relationship |  |

|  |
| --- |
| Problem |

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Provider |  | Primary Care Physician |  |

|  |  |  |
| --- | --- | --- |
| Injury/ Body Part Involved |  | Right  Left |

|  |  |  |
| --- | --- | --- |
| Last MD Visit |  | Have you previously been treated by a Physical Therapist this year? Yes  No |

|  |
| --- |
| Insurance Information |

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Insurance |  | Secondary Insurance |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Subscriber Name |  | Subscriber Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Subscriber DOB |  | Subscriber DOB |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Relationship to Subscriber |  | Relationship to Subscriber |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ID # |  | Group # |  | ID # |  | Group # |  |

|  |
| --- |
| Work Related Injury or Motor Vehicle Accident |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Work Related | MVA | Claim No. |  | Date of Injury |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Insurance Name |  | Insurance Billing Address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Claim Manager’s Name |  | Phone (     ) |  |

|  |  |
| --- | --- |
| **This is not work or accident related** |  |

|  |
| --- |
| Agreement |

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid

directly to the provider of service and I am financially responsible for non-covered services. I also authorize Innova Physical Therapy to release any information to referring/consulting physicians or other health care providers as deemed appropriate to facilitate my/our care.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature (Parent/ Guardian if patient is a minor) |  | Date |  |

Name:

Height:

Weight:

|  |
| --- |
| MEN’S PELVIC FLOOR INTAKE FORM |

**Describe the current problem that brought you here:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your problem first begin? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your first episode of the problem related to a specific incident? Yes / No

If so, please describe and specify date

Please check the appropriate box to describe the level of pain/ discomfort you are having today.

|  |  |
| --- | --- |
| 0= No pain | 10=Worst pain imaginable |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Please describe the timing of your symptom(s):**

|  |
| --- |
| Constant Comes and Goes Getting Worse Getting Better Keeps Me Awake |

**Do you have pain with any of the following? (circle all that apply):**

Valsalva Bowel Movement Coughing/sneezing Urination

Intercourse Jumping/running Urge (bowel or bladder)

Pelvic Symptom Questionnaire

### **Bladder Symptoms**

Daily fluid intake (1 glass is 8 oz or 1 cup) \_\_\_\_\_\_\_\_ glasses per day.

Of this total, how many glasses are caffeinated? \_\_\_\_\_\_\_\_ glasses per day.

Urinary frequency: \_\_\_\_\_\_ times per day, and \_\_\_\_\_ times per night.

Is your bladder urge: \_\_\_\_\_ strong, \_\_\_\_\_ medium, \_\_\_\_\_ small, \_\_\_\_\_\_ absent?

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?

\_\_\_\_\_\_\_\_\_\_ minutes, \_\_\_\_\_\_\_\_\_ hours, or \_\_\_\_\_ not at all.

Do you usually pass  Small  Medium  Large amounts of urine?

How many times do you wake up at night to empty your bladder?  0-2 3-4 5 or more

How long can you wait to void when you get an urge? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you leak urine when you (circle all that apply)?

Cough/sneeze laugh exercise run jump lift feel cold have intercourse

with triggers (hear running water, putting keys in door, or others)

If yes to leakage how much urine do you leak? Small or large?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Circle Yes or No:**

Y / N Do you have difficulty starting a stream?

Y / N Do you have an intermittent stream of urine?

Y / N Can you stop the flow of urine if you try?

Y / N Does your bladder feel empty after you void?

Y / N Do you strain, push, or bear down to void?

Y / N Do you dribble after you void?

Y / N Do you have constant urine leakage?

Y / N Do you have leakage with urgency?

Y / N Does it hurt to empty your bladder? Please specify type of pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y / N Do you empty your bladder to ease pain?

Y / N Can you tell when your bladder is full?

Y / N Do you wet your bed?

Y / N Do you restrict your fluid intake?

Y / N Do you use a form of leakage protection? \_\_\_ adult/maxi pad, \_\_\_ mini pad,

If yes, how often do you change your pad? \_\_\_\_\_ times per day.

**Bowel Symptoms**

Frequency of bowel movements: \_\_\_\_\_\_ times per day, \_\_\_\_\_\_ times per week, or \_\_\_\_\_\_\_.

Most common stool consistency? \_\_\_\_ liquid, \_\_\_\_ soft, \_\_\_\_ firm, \_\_\_\_ pellets, \_\_\_\_ other, please describe.

If you have constipation, do you have techniques to manage these symptoms? If so, please describe: \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When you have a normal urge to have a bowel movement, how long can you delay before you have to go to the toilet? \_\_\_\_\_ minutes, \_\_\_\_\_ hours, or \_\_\_\_\_ not at all.

**Please Circle Yes or No:**

Y / N Do you have a strong urge to move your bowels?

Y / N Do you strain to have a bowel movement?

Y / N Do you have pain with bowel movements?

Y / N Do you experience bowel leakage? How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y / N Do you have a sense of incomplete emptying after bowel movement?

Y / N Do you spend more than 10 minutes on the toilet?

Y / N Do you have difficulty holding gas?

Y / N Do you have diarrhea often?

Y / N Do you include fiber in your diet?

Y / N Do you take laxatives or use enemas regularly?

Y / N Bleeding with bowel movement?

**Intimacy Symptoms**

Y / N Are you sexually active? If not, do you avoid intimacy because of pain? Y / N

Y / N Do you have orgasms?

Y / N Pain with orgasm

Y / N Post-coital pain (after intercourse)

Are your symptoms getting better, worse or staying the same? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Have you received treatment for your current condition? | Yes No |

If yes describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Have you received any of the following services?  Physical Therapy Massage Therapy Chiropractic Acupuncture |

What testing has been completed for your current complaints? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have had testing, did it include any of the following?

|  |
| --- |
| Bone Scan MRI XRAY EMG CT Scan Blood Work Injections |

|  |  |
| --- | --- |
| Other: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |

**Prior Surgery:**

|  |  |
| --- | --- |
| **TYPE** | **DATE** |
|  |  |
|  |  |
|  |  |

**Medications:**

|  |  |  |
| --- | --- | --- |
| **NAME** | **DOSAGE** | **REASON FOR TAKING** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

How would you describe your current stress level?

|  |
| --- |
| Low  Medium  High |

**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

**What are your treatment goals/concerns?**

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

Describe your activity/exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have activity restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

Date of Last Annual Physical Exam Any Tests performed

Required

General Health (circle one): Excellent Good Average Fair Poor

Occupation Hours/week On disability or leave? Y / N

**Sexual History**

Y / N Sexually active

Y / N Pain with sexual activity

Y / N Use of Birth Control or Protection

Y / N Sexual abuse or trauma

Y / N Frequent UTIs

**Since the onset of your current symptoms have you had any of the following (circle all that apply):**

Fever/Chills Malaise (Unexplained tiredness) Unexplained weight change

Unexplained muscle weakness Dizziness or fainting Night pain/sweats

Change in bowel or bladder functions Numbness / Tingling

**Circle as many of the following conditions that apply to you and describe if necessary or check none apply:**

Allergies – list below Hepatitis  **Pelvic Health Related:**

Alcoholism/Drug Problems High blood pressure Pudendal Neuralgia

Anemia HIV/AIDS Childhood bladder issues

Anorexia/bulimia Hypothyroid/hyperthyroid Coccyx fracture/injury

Anxiety Irritable Bowel Syndrome Pelvic Congestion

Arthritic Conditions Kidney Disease Curvature of penis

Asthma Latex Sensitivity Hernia or hernia repair

Cancer Multiple Sclerosis Prostate enlargement

Chronic Fatigue Syndrome Musculoskeletal pain Erectile dysfunction

Depression Osteoporosis/osteopenia Injury to the penis

Diabetes Raynaud’s (cold hands and feet) Injury to the scrotum

Epilepsy/seizures Sexually transmitted disease Testicular mass

Fibromyalgia Sports Injuries Pain with ejaculation

Headaches Stroke Vasectomy

Head injury/trauma TMJ/neck pain Premature ejaculation

Hearing loss/problem Unusual stress at home/work

Heart problems Vision/eye problems

Other/Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

None of these conditions apply to me.

|  |
| --- |
| **MEN’S PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT** |

I 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 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 and external pelvic floor musculoskeletal examination. This examination is performed by observing and/or palpating the perineal region including the 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 rectal sensors for muscle biofeedback.

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

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.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that an internal and external pelvic floor examination are part of treatment of the pelvic floor for which I have been referred.
3. I understand that I can terminate the exam at any time.
4. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
5. **I have the option of having a second person/chaperone present in the room during the procedure and I (please check one of the following options)**

**choose to have second person/chaperone present**

**OR**

**decline to have a second person/chaperone**

*Patient may be required to supply their own second person/chaperone.*

*Innova will supply when possible.*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Parent or Guardian if patient is a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **FINANCIAL POLICY** |

**Standard Insurance Policy:**

*Innova* will bill your insurance carrier as a courtesy to you. However, you are ultimately responsible for payment for services you receive. If we are contracted with your insurance company, we must follow our contract and their requirements. **It is the insurance company that makes the final determination of your eligibility.**

**Costs you may be responsible for after insurance processes:**

**Deductible**

**Copayments**

**Non-Covered Services**

If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain the referral may result in a lower payment from the insurance company. Referrals are current for 90 days unless otherwise specified.

Copays are due at the time of service. It is your responsibility to know the amount of your copay. My copay is $      .

The balance on your monthly statement is due and payable when the statement is issued, and is past due if not paid by the due date on the statement. Payment plans are available upon request.

**Self-Pay Policy:**

*Innova* will apply a discount for patients without insurance coverage, or for those patients that have exceeded insurance benefits. Payment is due at the time services are rendered.

**Auto PIP/ Third Party Policy:**

We do not accept third-party or accident settlement *liens.* If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. We require that you allow us to bill your health insurance or pay our self-pay rates at the time of service.

**Cancellation Policy:**

The appointments made for you represent a time set aside specifically for you and your therapist. We value your time and ask that you value ours by giving at least 24 hours’ notice for any cancellations or changes to your appointment.

Patients who fail to provide **24 hours’ notice** will be charged a **$60.00 fee**. This fee is not billable to insurance and is due at your next scheduled appointment. Patients who cancel or no show on three separate occasions will be discharged from physical therapy and removed from the schedule. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge.

If you have any questions regarding this policy, please do not hesitate to contact our *Clinic Director* at: (425) 658-4980

**I understand the Financial Policies as described above. I acknowledge that I am financially responsible for any balance due on covered or non-covered services.**

|  |  |  |  |
| --- | --- | --- | --- |
| Signature (Parent/ Guardian if patient is a minor) |  | Date |  |

|  |
| --- |
| **PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES** |

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act (HIPAA). I have been given the right to review and receive a copy of Innova’s Notice of Privacy Practices. I understand that Innova Physical Therapy will use or disclose my health information for treatment, billing and healthcare operation. I understand that I have the right to request in writing how my private information is used or disclosed.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature  (Parent/ Guardian if patient is a minor) |  | Date |  |