|  |
| --- |
| 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:** | |
|  |
|  |
|  |

|  |
| --- |
| 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 pain:

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

Do you have pain with:

Y/N Tampon Use Y/N Valsalva Y/N Bowel Movement

Y/N Pelvic exams Y/N Coughing/sneezing Y/N Urination

Y/N Intercourse Y/N Jumping/running Y/N Urge (bowel or bladder)

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

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

|  |
| --- |
| Physical Therapy Massage Therapy Chiropractic Acupuncture |

**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?

**Since the onset of your current symptoms have you had:**

Y/N Fever/Chills Y/N Malaise (Unexplained tiredness)

Y/N Unexplained weight change Y/N Unexplained muscle weakness

Y/N Dizziness or fainting Y/N Night pain/sweats

Y/N Change in bowel or bladder functions Y/N Numbness / Tingling

**Health History**

Date of Last Physical Exam Tests performed

Date of Last Pap smear Tests performed

**General Health:**  Excellent Good Average Fair Poor

Occupation Hours/week On disability or leave?

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

Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activity Restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle as many of the following conditions that apply to you and describe if necessary:**

Allergies – list below Hepatitis Pelvic Health Related:

Alcoholism/Drug Problems High blood pressure Amenorrhea

Anemia HIV/AIDS Childhood bladder issues

Anorexia/bulimia Hypothyroid/hyperthyroid Coccyx fracture/injury

Anxiety Irritable Bowel Syndrome Dysmenorrhea

Arthritic Conditions Kidney Disease Endometriosis

Asthma Latex Sensitivity Fibroids

Cancer Multiple Sclerosis Interstitial Cystitis

Chronic Fatigue Syndrome Musculoskeletal pain Menopause- when? \_\_\_\_

Depression Osteoporosis/osteopenia Pelvic Congestion

Diabetes Raynaud’s (cold hands and feet) Physical or Sexual Abuse

Epilepsy/seizures Sexually transmitted disease Pudendal Neuralgia

Fibromyalgia Sports Injuries Vestibulitis

Headaches Stroke Vulvodynia

Head injury/trauma TMJ/neck pain

Hearing loss/problem Unusual stress at home/work

Heart problems Vision/eye problems

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

**OB History**

Y/N Pregnancies # \_\_\_ Y/N Episiotomy or Tears

Y/N Vaginal deliveries #\_\_\_ Y/N Prolapse or organs falling out

Y/N C-section #\_\_\_ Y/N Pelvic pain

Y/N Trouble healing after delivery Y/N Other/describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GYN History**

Y/N Sexually active Y/N Menses – Age of onset \_\_\_\_

Y/N Pain with vaginal penetration Y/N Pain with ovulation or menses

Y/N Use of Birth Control or Protection Y/N Regular cycles

Y/N Sexual abuse or trauma Y/N Frequent UTIs

Have you had any of the following tests:

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

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

**Prior Surgery:**

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

**Medications:**

|  |  |  |
| --- | --- | --- |
| **NAME** | **DOSAGE** | **REASON FOR TAKING** |
|  |  |  |
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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 leak urine when you (circle all that apply): cough/sneeze, laugh, exercise, run, jump, lift, feel cold, have intercourse, or with triggers (hear running water, putting keys in door, or others)?

Y/N Do you wet your bed?

Y/N Do you have pain or burning with urination?

Y/N Do you have difficulty starting a stream?

Y/N Do you strain to empty your bladder?

Y/N Do you feel unable to fully empty?

Y/N Do you have a feeling of “falling out”?

Y/N Do you have leakage with urgency?

Y/N Do you restrict your fluid intake?

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

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.

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 leak or stain feces?

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?

**Intimacy Symptoms**

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

Y/N Pain with vaginal penetration: Deep or Initial?

Y/N Do you tolerate manual sex?

Y/N Do you tolerate oral sex?

Y/N Do you need to use lubrication?

Y/N Do you have orgasms?

Y/N Pain with orgasm

Y/N Post-coital pain (after intercourse)

|  |
| --- |
| **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 childbirth or 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 pelvic floor musculoskeletal examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or 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 vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal 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 I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. **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 |  |