INNER DYNAMICS PHYSICAL THERAPY

Last Name:_____ Date of Birth:_____Age:_____
First Name:_____ Social Security #:_____
Address:_____ Gender: M or F Marital Status: M S D W
_____ Referring Doctor:_____
Cell Phone:_____ Diagnosis:_____
Home Phone:_____ Date Problem Started:_____
Work Phone:_____ Date of Surgery:_____
E-Mail:_____

INSURANCE INFORMATION

Primary Insurance:_____
Policy ID#:_____Group #_____
Phone #:_____
Effective Date:_____ Subscriber:_____
Relationship to Subscriber:_____ Subscribers Date of Birth:_____

Secondary Insurance:_____
Policy ID#:_____Group #_____
Phone #:_____
Effective Date:_____ Subscriber:_____
Relationship to Subscriber:_____ Subscribers Date of Birth:_____

PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION

Parent/ Legal Guardian Name:_____ **Emergency Contact:**_____
Address(if different that child):_____ Relationship:_____
_____ Contact Cell Phone:_____
Phone#:_____ Contact Home Phone:_____

I, the above named person (or their legal guardian), consent to the administration of treatment rendered via Inner Dynamics Physical Therapy(IDPT) and its professional staff as prescribed by my physician. I authorize the release of any records of information about me to obtain payment for charges incurred by me at IDPT, and for the purpose of communicating with my physician or other health care provider. I agree to pay IDPT any charges that I am responsible for such as co-pays, co-insurance, or any non-covered charges. I hereby assign benefits, otherwise payable to me or my dependents, directly to IDPT. I understand that IDPT, will verify my insurance, but I realize benefits will not be guaranteed by this office, and I am ultimately financially responsible for my account. I agree that I have been advised of my benefits as they were explained to IDPT by my insurance company.

Signature of Patient or Guardian:_____Date:_____

Inner Dynamics Physical Therapy

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

If you wish for us to talk about your care to anyone else please list their name and relationship to you (ex: spouse, mother, father, brother, sister, power of attorney).

_____

_____

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

INNER DYNAMICS PHYSICAL THERAPY

EMAIL COMMUNICATION AND NEWSLETTER FORM

NAME:_____

EMAIL ADDRESS:_____

If you would like to receive email reminders for upcoming appointments at **Inner Dynamics Physical Therapy**, please check here.

___ **Yes,** I would like to receive **emails** for my upcoming appointments.

___**No,** I would like to receive **phone calls** for my upcoming appointments.

As a new patient, we invite you to learn more about what's going on at **Inner Dynamics Physical Therapy** via our weekly newsletter!

We love sending out information including:

- New videos posted to facebook, youtube or instagram of exercise routines
- Future activities or events
- Research articles
- Motivational quotes or stories
- Updates regarding our practice

Please check here.

___**Yes,** please sign me up for your weekly newsletter.
___**No,** I do not want to receive updates and inspirational stories.

At any time you can opt-out of our email services. No personal information will be shared via our email services unless a patient has provided full disclosure to share a story with others. Your email address will only be used for the sole purposes listed above and will never be utilized for any other services.

PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms

Your answers to the following questions will help us to manage your child's care better. Please complete all pages **prior to** your child's appointment.

Name of parent or guardian completing this form_____

Child's name:_____Prefers to be called _____ Date: _____

Age _____Grade_____Height _____Weight_____

Describe the reason for your child's appointment_____

When did this problem begin? _____Is it getting better_____worse_____staying the same _____

Name and date of child's last doctor visit _____

Date of last urinalysis_____

Previous tests for the condition for which your child is coming to therapy. Please list tests and results_____

_____

_____

_____

Medications	Start date	Reason for taking
_____	_____	_____
_____	_____	_____

Has your child stopped or been unable to do certain activities because of their condition? For example, embarrassed to play with friends, can't go on sleepovers, feels ashamed about leakage and avoids play dates. _

_____

_____

Does your child now have or had a history of the following? Explain all "yes" responses below.

Y/N Pelvic pain
Y/N Low back pain
Y/N Diabetes
Y/N Latex sensitivity/allergy
Y/N Allergies
Y/N Asthma
Y/N Surgeries
Y/N Blood in urine
Y/N Kidney infections
Y/N Bladder infections
Y/N Vesicoureteral reflux Grade ____
Y/N Neurologic (brain, nerve) problems
Y/N Physical or sexual abuse
Y/N Other (please list)_____

Explain yes responses and include dates_____

Does your child need to be catheterized? Y/N If yes, how often? _____

Bladder Habits

1. How often does your child urinate during the day? _____times per day, every _____ hours.
2. How often does your child wake up to urinate after going to bed? _____times
3. Does your child awaken wet in the morning? Y/N If yes, _____ days per week.
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y/N
5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)
   - ___ Not at all
   - ___ 1-2 minutes
   - ___ 3-10 minutes
   - ___ 11-30 minutes
   - ___ 31-60 minutes
   - ___ Hours
6. Does your child take time to go to the toilet and empty their bladder? Y/N
7. Does your child have difficulty initiating the urine stream? Y/N
8. Does your child strain to pass urine? Y/N
9. Does your child have a slow, stop/start or hesitant urinary stream? Y/N
10. Is the volume of urine passed usually: Large Average Small Very small (circle one)

11. Does your child have the feeling their bladder is still full after urinating? Y/N
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? Y/N

13. Fluid intake (one glass is 8 oz or one cup)
    ___ of glasses per day (all types of fluid)
    ___ of caffeinated glasses per day
    Typical types of drinks _____
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e. running water, etc.) Y/N please list_____

Bowel Habits

15. Frequency of movements: ___ per day _____ per week. Consistency: loose__ normal___ hard__
16. Does your child currently strain to go? Y/N_____ Ignore the urge to defecate? Y/N_____
17. Does your child have fecal staining on his/her underwear? Y/N How often?_____
18. Does your child have a history of constipation? Y/N_____How long has it been a problem?

SYMPTOM QUESTIONNAIRE

1. Bladder leakage (check all that apply)
   ___ Never
   ___ When playing
   ___ While watching TV or video games
   ___ With strong cough/sneeze/physical exercise
   ___ With a strong urge to go
   ___ Nighttime sleep wetting
2. Frequency of urinary leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day
   ___ Constant leakage
3. Severity of leakage (circle one)
   ___ No leakage
   ___ Few drops
   ___ Wets underwear
   ___ Wets outer clothing
4. Bowel leakage (check all that apply)
   ___ Never
   ___ When playing
   ___ While watching TV or video games
   ___ With strong cough/sneeze/physical exercise
   ___ With a strong urge to go
5. Frequency of bowel leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day
6. Severity of leakage (circle one)
   ___ No leakage
   ___ Stool staining
   ___ Small amount in underwear
   ___ Complete emptying
7. Protection worn (circle all that apply)
   ___ None
   ___ Tissue paper / paper towel
   ___ Diaper
   ___ Pull-ups
8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10
   0_____10
   Not a problem Major problem
9. Rate the following statement as it applies to your child's life today
   My child's bladder is controlling his/her life.
   0_____10
   Not true at all Completely true

PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also 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 or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist.

Potential benefit: I may experience 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.

Cooperation with treatment:

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 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, I will pay a cancellation fee of $45

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of Inner Dynamics Physical Therapy.

Date_____ Patient Name: _____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

_____
Witness Signature