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:_____

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.

Patient History

Name _____ **DOB**_____ **Age**___ **Date**_____

1. Describe the current problem that brought you here?_____

_____

2. When did your problem first begin?_____

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

_____

4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how?_____

5. If pain is present rate pain on a 0-10 scale 10 being the worst._____ Describe the nature of the pain (i.e. constant burning, intermittent ache)_____

_____

6. Describe previous treatment/exercises_____

_____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than_____ minutes
___ Walking greater than _____minutes
___ Standing greater than _____ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list _____

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers i.e. /key in door
___ With nervousness/anxiety
___ No activity affects the problem

8. What relieves your symptoms?_____

_____

9. 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 _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst __

11. 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

Y/N Other /describe_____
Date of Last Physical Exam _____ Tests performed_____

_____

Pg 2 History **Name** _____ **DOB** _____ **Age** _____

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____
Mental Health: Current level of stress High___ Med___ Low___ Current psych therapy? Y/N

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 and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe_____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

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_____		

Medications - pills, injection, patch	Start date	Reason for taking

Over the counter -vitamins etc	Start date	Reason for taking

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 toilet? _____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
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

10b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

11a. On average, how much urine do you leak?
___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

11b. How much stool do you lose?
___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying
___ 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

Pelvic Floor Consent for Evaluation and Treatment

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy evaluation and 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 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, 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 muscle 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 also include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to the following: observation, palpation, 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.

Potential risks:

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 1-3 days, I agree to contact my therapist.

Potential benefits:

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 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 business hours in advance, I will not be charged. I understand that if I cancel less than 24 business hours in advance, weekends are not business hours, I will pay a cancellation fee of $45.

Initials_____

No warranty: I understand that the physical 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 physical therapy 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 at Inner Dynamics Physical Therapy.

Date **Patient Name:**

(Please Print)

Patient Signature

Signature of Parent or Guardian (If applicable)

Witness Signature

Plan of Care Agreement

My diagnosis, evaluation findings including the treatment program, the expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program have all been explained to me. My questions about my care have been answered to my understanding and satisfaction. I consent to the recommended course of treatment.

For optimum care and progress:

- It is important to keep your regularly scheduled therapy appointment. At those visits, we can modify and progress your exercise routine.
- Please avoid practicing your pelvic floor exercises just before your next appointment time.
- Bring your exercise sheets, voiding log, and biofeedback internal sensors and any other equipment that may be needed to each office visit.

Date

Patient Name (Please Print)

Patient Signature

Signature of Parent or Guardian
(If applicable)

Therapist Signature