

PATIENT INFORMATION

PLEASE PRINT

NAME _____ DATE OF BIRTH _____ AGE _____

NAME OF PARENT/GUARDIAN IF MINOR _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

CELL#(_____) _____ HM#(_____) _____ WK#(_____) _____

MAY WE LEAVE MESSAGES AT THESE NUMBERS? Y N - CL HM WK

MAY WE CONTACT YOU VIA EMAIL? Y N EMAIL _____

EMERGENCY CONTACT _____ PHONE#(_____) _____

REFERRAL _____

PHONE#(_____) _____ FAX#(_____) _____

FINANCIAL AND INSURANCE RESPONSIBILITIES

We have elected to no longer be a preferred provider for insurance companies. Instead, we provide physical therapy on a **“pay at time of service”** basis. By removing ourselves from contracted status with insurance companies, we do not have to limit the time or quality of treatment we provide because of insurance company restrictions or elevate our rates to pay for billing services.

We recommend you call your insurance company to completely understand your physical therapy benefits.

I agree to pay DPT for my treatments at the time of service by cash, check or debit, Visa, Mastercard or I agree to pay DPT for my treatments at time of service, by cash, check, or debit, Visa, MasterCard or Discover.

_____ (Initial)

CANCELLATION POLICY

I understand if I cancel more than 24 hours in advance, I will not be charged a cancellation fee. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of \$75.00. _____ (Initial)

By signing this document I agree to the conditions stated in this form:

Patient/Guardian Signature _____ Date _____

CONDITIONS & CONSENT FOR PHYSICAL THERAPY AT DESERT PT

COOPERATION WITH TREATMENT

I understand that in order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist. _____(Initial)

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 physical therapist can share with me opinions and available statistics and studies regarding results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. _____(Initial)

INFORMED CONSENT FOR TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services. I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. I understand that I can decline any portion of the evaluation or treatment at any time. _____(Initial)

Please initial one below:

_____ I would like a witness in the room for physical therapy evaluation and/or treatment.

_____ I do not need a witness

Potential risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition.

Potential benefits: May include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You will have greater knowledge about managing your condition and the resources available to you.

Alternatives: All physical therapy treatment options available to your conditions will be explained to you. You may inquire about the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your primary care physician. _____(Initial)

I have read the above information and I consent to physical therapy evaluation and treatment. I understand the risks, benefits, and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

Patient/Guardian Signature

_____/_____/_____
Date

****FOR THERAPIST USE ONLY****

Consent to evaluation/treatment was verbally discussed with patient.

Therapist Signature

_____/_____/_____
Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

PATIENT NAME: _____ DOB: _____

Notice of Privacy Practices

The notice provides the uses and disclosures of my protected health information (PHI) that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that if I have questions or complaints regarding my privacy rights I may contact the person below.

I understand that the practice reserves the right to change the terms of its Notice of Privacy Practices. I can obtain this practice's current Notice of Privacy Practices online or at the clinic upon request.

PATIENT/GUARDIAN SIGNATURE

DATE

____ Patient refused to Sign

____ Patient was unable to sign because _____

Contact Person: Erika Townsend, PT, DPT – (602) 264-3369

RESTORE PELVIC HEALTH PHYSICAL THERAPY
(located within Desert Physical Therapy & Pelvic Health)
5040 E. Shea Blvd., Suite 261
Scottsdale, AZ 85254

RESTORE PELVIC HEALTH PHYSICAL THERAPY
5040 E. SHEA BLVD., SUITE 261
SCOTTSDALE, AZ 85254
Phone: 602-264-3369 Fax: (602) 264-3368

Date: _____

History Form

Patient Name: _____

DOB: _____ **Referring Provider:** _____

Currently working? Yes or No **Occupation:** _____

Reason for Physical Therapy: _____

When did this problem start? _____

Did a specific incident cause it? If yes, please describe: _____

Are your symptoms _____ **staying the same,** _____ **getting better,** _____ **getting worse?**

Have you had physical therapy in the past for these symptoms? Yes or No (circle)

What are your goals for Physical Therapy? _____

Medications (include reasons and supplements): _____

Allergies: _____

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

Other /describe: _____

Please indicate if you are experiencing or have experienced any of the following:

<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	High Blood pressure	<input type="checkbox"/>	Pelvic Pain
<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Physical Abuse
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hypo/Hyperthyroid	<input type="checkbox"/>	Sexual Abuse
<input type="checkbox"/>	Depression	<input type="checkbox"/>	IBS	<input type="checkbox"/>	STD's
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Interstitial Cystitis	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	TIA
<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	TMJ
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	Vision Problems

Anything other conditions that I should be aware of? _____

Surgeries	Date	Reason
Abdominal		
Bladder		
Bowel		
Uterine		
Orthopedic/Spine		
Heart		
Lungs		
Plastics		
Other		

Childbearing History

Are you currently Pregnant? Yes/No _____ Due Date: _____
 Number of Children: _____ Number of Vaginal deliveries: _____
 Number of C-sections: _____ Number of episiotomies: _____
 Number of forceps deliveries: _____ Any complications?: _____

Current Sexual Activity? (check all that apply)

____ Sexually Inactive due to pain
 ____ Pain with Penetration ____ Pain with Climax
 ____ Pain after intercourse? How long does it last? _____
 ____ Sexually inactive due to other reasons
 ____ No pain with intercourse

Bladder:

Y / N Difficulty initiating urine stream? **Y / N** Pain during urination?
Y / N Sensation of incomplete bladder emptying? **Y / N** Blood in urine?
Y / N Urine loss with sneezing, coughing, laughing? **Y / N** Insensible urine loss?
Y / N Urine loss with urgency to void? **Y / N** Dribbling after urination?
Y / N Straining to empty bladder?
 Is urine stream **weak, strong, or does it stop start?** (circle)
 How many times a day do you void? _____ Per Night? _____
 Do you wear pads? **Yes** or **No** How many per day/week? _____
 Do you have a sensation of something “falling out”? **Yes** or **No**

Bowel:

Y / N Loss of stool beyond your control? **Y / N** Straining to empty bowels?
Y / N Pain during bowel movements? **Y / N** Sensation of incomplete bowel movements?
Y / N Loss of flatulence (gas) beyond your control?
 How Many bowel movements per day/week? _____
 Is your stool (circle): **Loose/Liquid Soft Hard Pellets**

If you are experiencing pain, please indicate your pain level below:

0 _____ 10
0= no pain 10=ER Visit

How would you describe your pain? (circle all that apply)

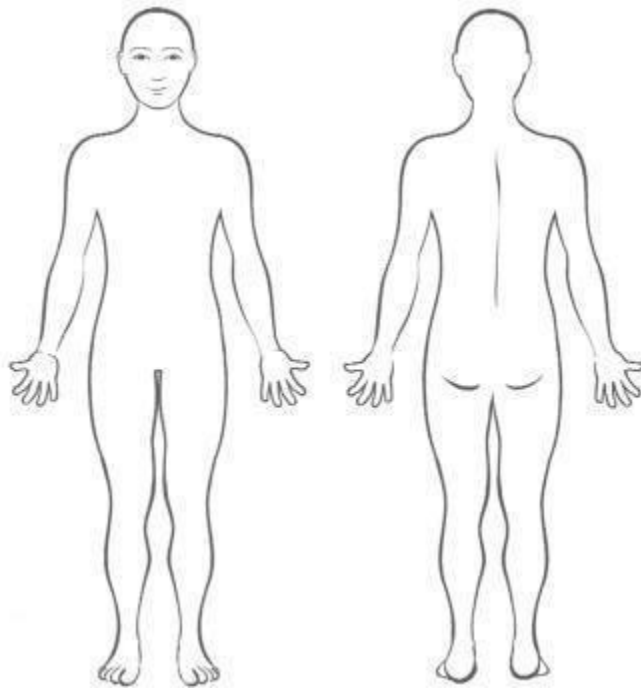
Aching Stabbing Shooting Sharp Dull
Constant Tingling Intermittent Pressure Numb

Other: _____

What increases your pain? _____

What decreases your pain? _____

Indicate where you are having pain below:



Front

Back

Please indicate your stress level below:

0=no stress _____ 10= extreme stress