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Pelvic Health Program

PATIENT REGISTRATION / INFORMATION SHEET

Name: _____
LAST FIRST MIDDLE

Date of Birth: _____ **Gender**: M F **Marital Status**: _____

Social Security Number: _____ **Email Address**: _____

Street Address: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell Phone**: _____

Race: American Indian Asian African American Native Hawaiian White Other Unknown

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown

Religious Preference: _____ **Primary Language**: _____

Employment Status: Full-Time Part-Time Not Employed On Active Military Duty Retired
Disabled Self Employed Student Full-Time Student Part-Time

Employer:_____ **Occupation**: _____

Street Address: _____

City: _____ **State**: ____ **Zip**: _____ **Work Phone**: _____

Date of Retirement: _____ **Spouses Retirement Date:**_____
IF APPLICABLE FOR MEDICARE PATIENTS

Emergency Contact: _____ **Relationship**: _____

Home Phone: _____ **Cell Phone**: _____

Insurance Primary Subscriber Name: _____
LAST FIRST MIDDLE

Relationship: _____ **Date of Birth:** _____ **Gender**: M F

Street Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Employment Status: _____ **Employer**: _____

Primary Care Physician: _____ **Phone Number:** _____

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For what reason are you seeking treatment? (check all that apply)

BLADDER SYMPTONS:

___ urinary incontinence (problem with bladder control)
___ urinary urgency (rushing to the toilet)
___ urinary frequency (too frequent voiding)
___ problem with bladder emptying (feeling incomplete bladder emptying after urinating)
___ pain with bladder emptying
___ other (please describe)_____

BOWEL SYMPTOMS:

___ fecal incontinence (problem with bowel control)
___ problem with bowel urgency (rushing to toilet)
___ problem with bowel emptying (feeling of incomplete bowel emptying after a bowel movement)
___ pain with bowel emptying
___ other (please describe)_____

For those with a vagina:

___ pelvic prolapse (bulge or protrusion in the vagina)
___ pain with vaginal penetration
___ pelvic pain (please describe WHERE you have pain)_____

For those with testicles:

___ pain with erection
___ pain with ejaculation
___ pelvic pain (please describe WHERE you have pain)_____

PAIN

If you have **pain related to why you are here**, please indicate how much pain you experience on the scale below where 0= no pain and 10=most severe pain:

0 1 2 3 4 5 6 7 8 9 10

Please describe the pain (location, when it started and why, description, frequency):

_____

_____

What makes your pain worse?_____

What makes your pain better?_____

What treatments have you tried or what have you done to improve your symptoms?

_____

_____

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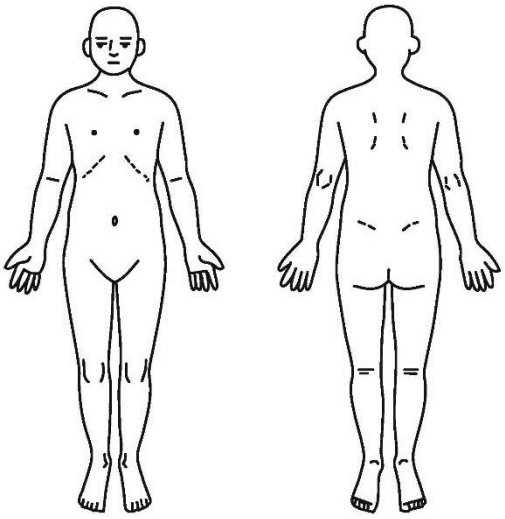
PLEASE USE AN "X" TO INDICATE YOUR PAIN ON THE FIGURE BELOW:



OBSTETRIC HISTORY (if applicable)

How many pregnancies have you had? ____

How many children have you given birth to? ___ vaginal ___ cesarean section

Did you have any of the following? (please check all that apply)

___ perineal tear ___ vacuum delivery

___ forceps ___ baby weighing 8 pounds or more

___ episiotomy ___ other:_____

MENSTRUAL HISTORY (if applicable)

When was your last menstrual period? _____

Are you pregnant? ___ yes ___ no

Type of birth control used (if applicable)? _____

Have you gone through menopause? ___ yes ___ no

HORMONE THERAPY (if applicable)

Are you using any hormones? ___yes ___no

___ Estrogen ___ Progesterone ___ Testosterone ___ other (describe:_____)

BLADDER SYMPTOMS

How much time in between urinating during the day? _____

How many times do you wake up at night to urinate? _____

Do you have difficulty starting urination? ___ yes ___ no

Do you strain to urinate? ___ yes ___ no

Is your urine flow weak? ___ yes ___ no

Do you leak *immediately* after emptying your bladder (when you walk away from the toilet)? ___ yes ___ no

Do you get frequent bladder infections? ___ yes ___ no

Are you able to stop your urine flow intentionally? ___ yes ___ no ___ never tried

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URINE LEAKAGE (if you have unintentional loss of urine, please answer the following questions)
Number of pads used for urine loss per day: ____

ICIQ:
How often do you leak?
___ never
___ about once a week or less (1)
___ two or three times a week (2)
___ about once a day (3)
___ several times a day (4)
___ all the time (5)

We would like to know how much urine you think leaks?
___ none (0)
___ a small amount (2)
___ a moderate amount (4)
___ a large amount (6)

Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal).

0 1 2 3 4 5 6 7 8 9 10

Activities associated with urine loss (check all that apply):

coughing	bending
sneezing	lifting
laughing	sleeping
walking	anxiety/stress
jumping	Sexual activity/climax
exercise	with a strong urge to urinate
sit to stand	on the way to the toilet

BOWEL SYMPTOMS
Have you ever seen blood in your stool? ___ yes ___ no ___ hemorrhoids
How many bowel movements do you have? ___ per day ___ per week
Bowel symptoms (please check all that apply):
___ loose stool
___ normal stool
___ constipated
___ fecal incontinence
___ unable to control gas
___ strain to pass stool

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Do you have pain when you empty your bowels? ___ yes ___ no
Do you get a feeling that your bowels are not completely empty after a bowel movement? ___ yes ___ no
Do you get a strong sense of urgency to have a bowel movement? ___ yes ___ no
Do you lose stool unintentionally if stool is loose? ___ yes ___ no
Do you lose stool unintentionally if stool is well formed? ___ yes ___ no
Do you take any fiber supplements, laxatives, or stool softeners? ___ yes ___ no
If yes, please list:

_____
_____

SEXUAL SYMPTOMS

Are you sexually active? ___ yes ___ no
With ___ men ___ women ___ both
Do you have any sexually transmitted diseases? ___yes (please list below) ___no

_____

Do you experience any pain or discomfort with sexual activity? ___ yes ___ no

Are you able to achieve an erection ?___ yes ___ partial ___ no

Have you ever been forced to engage in sexual activity against your will? ___ yes ___ no

What is your current activity level?

___ sedentary ___ light ___ moderate ___ heavy
What do you do for exercise/ fitness and how often do you do this?

_____
_____

WHAT ARE YOUR GOALS FOR TREATMENT?

Please identify ONE ACTIVITY that is difficult or that you are unable to perform due to the condition you are seeking treatment for and rate that difficulty on the scale below:

Activity: _____

0 1 2 3 4 5 6 7 8 9 10
Unable to perform Performs easily

Is there anything else you would like to add?

_____
_____
_____

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Please list ALL of your medications:

Medication	Dose	Frequency	Medication	Dose	Frequency

Please check any of the following medical conditions that you have or have had:

Arthritis	Epilepsy	Multiple sclerosis	OTHER:
Asthma	Fibromyalgia	Osteoarthritis	
Bronchitis	Fractures/type:_____	Osteoporosis	
Cancer/type:_____	Heart problems	Scoliosis	
Carpal tunnel	Hepatitis	Stroke	
Depression	High blood pressure	Thyroid disease	
Diabetes	Kidney disease	Tuberculosis	

History of depression or anxiety? If so, have you found successful treatments? Please explain._____

Have you had any back, hip, or pelvic injuries? Please describe:

_____

_____

Please list ALL surgeries and the dates they were performed:

_____

_____

Do you have an implanted device? (Interstim, IUD, pacemaker)_____

Please indicate whether you have had any special tests or procedures (with dates) for your bladder or bowel:

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Do you have any drug allergies? ___ yes ___ no

If yes, what are they?

_____

_____

Do you have any other allergies? (latex, tape, iodine/contrast) ___yes ___no
If yes, what are they?_____

Please identify how you learn best (circle all that apply):

Reading Listening Observation Performance

Have you fallen in the last year? ___ yes ___ no
How many times_____
Do you feel unsteady when standing/walking? ___ yes ___ no
Do you worry about falling? ___ yes ___ no
Do you use or were told to use a cane or walker to get around safely? ___ yes ___ no
Do you have to steady yourself on furniture when moving about in your home? ___ yes ___ no
Do you need to push with your hands to stand up from a chair? ___ yes ___ no
Do you have trouble stepping onto a curb? ___ yes ___ no
Do you often have to rush to the toilet? ___ yes ___ no no
Have you lost some of the feeling in your feet? ___ yes ___ no
Do you take medicine that makes you feel light-headed or tired? ___ yes ___ no
Do you take medicine to help you sleep or improve your mood? ___ yes ___ no
Do you often feel sad or depressed? ___ yes ___ no

Because violence in the home is a serious health risk, we ask everyone:

Do you have any concerns for your personal safety? __Yes__No
Do you feel safe in your current relationship or home? ___ yes ___ no
Is anyone in your life misusing your money or property? ___ yes ___ no
Have you been hit, slapped, physically hurt or threatened by your partner? ___ yes ___ no

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FINANCIAL POLICY

I understand and agree, regardless of my insurance status, that I am ultimately responsible for the payment of all services provided to me by Hoag Pelvic Health Program. All financial arrangements made, including copays, apply solely to the dates of service covered by my insurance company. Should my insurance deny payment or portion of payment for any reason, all charges will be my financial responsibility. I hereby authorize my insurance benefits of any kind to be paid directly to Hoag Pelvic Health Program. I further authorize Hoag Pelvic Health Program to release any medical records or information to any insurance company as necessary or required to process my insurance claims. In the event that it is necessary for Hoag Pelvic Health Program to refer your unpaid account to an attorney for legal action, including the filing of a claim for monetary damages, and should Hoag Pelvic Health Program be successful in obtaining a judgement against you, then you agree to pay in addition to the balance due, all applicable charges, attorney's fees and costs that the court may access against you.

I CERTIFY THAT I HAVE READ THIS DOCUMENT IN IT'S ENTIRETY AND AGREE TO THE TERMS & CONDITIONS WITHIN. I AGREE THAT THE ABOVE INFORMATION IS CORRECT AND TO THE PLAN OF CARE SET FORTH TO ME BY MY PHYSICAL THERAPIST.

PRINT NAME: _____
PATIENT SIGNATURE: _____**DATE:**_____

CANCELLATION POLICY

We understand that life gets busy and has unexpected twists, but we ask that you please respect our time as well as other patients in need of therapy. In order to best serve all patients, you will be allowed **one** emergency last-minute cancellation. After that, Hoag Pelvic Health Program cancellation policy will be enforced.

Hoag Pelvic Health Program CANCELLATION POLICY:

WE MUST BE NOTIFIED AT LEAST 48 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT OR YOU WILL BE RESPONSIBLE FOR A $50 CANCELLATION FEE.

This fee is your responsibility. Insurance does not pay for missed appointments or late cancellations. Please understand that our therapists' time is valuable and we would like to see all patients who are in need of treatment. This policy allows us to strive for that goal and to be fair to everyone.

I HAVE READ THE Hoag Pelvic Health Program CANCELLATION POLICY ABOVE & AGREE TO ABIDE BY ITS TERMS.

PRINT NAME: _____
PATIENT SIGNATURE: _____**DATE:**_____

APPOINTMENT REMINDER NOTIFICATION PREFERENCES

You give us permission to provide appointment reminders by phone, email or text.

BY SIGNING BELOW YOU ARE AUTHORIZING HOAG PELVIC HEALTH PROGRAM TO USE THE ABOVE METHOD OF CONTACT.

PRINT NAME: _____
PATIENT SIGNATURE: _____**DATE:**_____

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NOTICE OF PRIVACY PRACTICES

_____(initial) I AUTHORIZE EMPLOYEES FROM HOAG PELVIC HEALTH PROGRAM TO LEAVE ME A VOICEMAIL WITH PROTECTED HEALTH INFORMATION.

_____ (initial) I AUTHORIZE EMPLOYEES FROM HOAG PELVIC HEALTH PROGRAMTO SEND ME EMAILS WITH PROTECTED HEALTH INFORMATION.

HOAG PELVIC HEALTH PROGRAM EMPLOYEES MAY LEAVE A VOICEMAIL WITH PROTECTED HEALTH INFORMATION TO THE FOLLOWING NUMBER: _____

TO OUR PATIENTS, THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF HOAG PELVIC HEALTH PROGRAM) MAY BE USED & DISCLOSED, & HOW YOU CAN OBTAIN ACCESS TO YOUR HEALTH INFORMATION. THIS IS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA). HOAG PELVIC HEALTH PROGRAM IS DEDICATED TO MAINTAINING. THE PRIVACY OF YOUR HEALTH INFORMATION. WE ARE REQUIRED BY LAW TO MAINTAIN THE CONFIDENTIALITY OF YOUR HEALTH NFORMATION. WE REALIZE THAT THESE LAWS ARE COMLICATED, BUT WE MUST PROVIDE YOU WITH THE FOLLOWING IMPORTANT INFORMATION:

THE FOLLOWING CIRCUMSTANCES MAY REQUIRE US TO USE OR DISCLOSE YOUR HEALTH INFORMATION:

1. TO PUBLIC HEALTH AUTHORITIES & HEALTH OVERSIGHT AGENCIES THAT ARE AUTHORIZED BY LAW TO COLLECT INFO.
2. LAWSUITS AND SIMILAR PROCEEDINGS IN RESPONSE TO A COURT OR ADMINSTRATIVE ORDER.
3. IF REQUIRED TO DO SO BY A LAW ENFORCEMENT OFFICIAL.
4. WHEN NECESSARY TO REDUCE OR PREVENT A SERIOUS THREAT TO THE HEALTH & SAFETY OF ANOTHER INDIVIDUAL OR THE PUBLIC. THESE DISCLOSURES WILL ONLY BE MADE WITH PERSONS OR ORGANIZATIONS WHO ARE ABLE TO HELP PREVENT SUCH A THREAT.
5. IF YOU ARE A MEMBER OF U.S. OR FOREIGN MILITARY (INCLUDING VETERANS) AND IF REQUIRED BY THE APPROPRIATE AUTHORITIES.
6. TO FEDERAL OFFICIALS FOR INTELLIGENCE AND NATIONAL SECURITY ACTIVITIES AUTHORIZED BY LAW.
7. TO CORRECTIONAL INSTITUTIONS OR LAW ENFORCEMENT OFFICIALS IF YOU ARE AN INMATE/UNDER THE CUSTODY OF A LAW ENFORCEMENT OFFICIAL.
8. FOR WORKERS COMPENSATION AND SIMILAR PROGRAMS.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. COMMUNICATIONS: YOU CAN REQUEST THAT HOAG PELVIC HEALTH PROGRAM COMMUNICATE WITH YOU ABOUT YOUR HEALTH & RELATED ISSUES IN A PARTICULAR MANNER OR AT A CERTAIN LOCATION. FOR INSTANCE, YOU MAY ASK THAT WE CONTACT YOU AT HOME RATHER THAN WORK. WE WILL ACCOMMODATE ALL REASONABLE REQUESTS.
2. YOU CAN REQUEST A RESTRICTION IN OUR USE OR DISCLOSURE OF YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. ADDITIONALLY, YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRCIT DICLOSURE OF YOUR HEALTH INFORMATION TO ONLY CERTAIN INDIVIDUALS INVOLDED IN YOUR CARE OR THE PAYMENT FOR YOUR CARE, SUCH AS FAMILY MEMBERS & FRIENDS. WE ARE NOT REQUIRED BY LAW TO AGREE TO YOUR REQUEST; HOWEVER, IF WE DO AGREE WE ARE BOUND BY OUR AGREEMENT EXCEPT WHEN OTHERWISE REQUIRED BY LAW, IN EMERGENCIES, OR WHEN THE INFORMATION IS NECESSARY TO TREAT YOU.
3. YOU HAVE THE RIGHT TO INSPECT AND OBTAIN A COPY OF THE HEALTH INFORMATION THAT MAY BE USED TO MAKE DECISIONS ABOUT YOU, INCLUDING PATIENT & MEDICAL RECORDS AND BILLING RECORDS, BUT NOT INCLUDING PSYCHOTHERAPY NOTES. YOU MUST SUBMIT YOUR REQUEST IN WRITING TO HOAG PELVIC HEALTH PROGRAM OR CONTACT THE OFFICE FOR FURTHER INFORMATION.

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4. YOU MAY ASK US TO AMEND YOUR HEALTH INFORMATION IF YOU BELIEVE IT IS INCORRECT OR INCOMPLETE, AND AS LONG AS THE INFORMATION IS KEPT BY OR FOR OUR PRACTICE. TO REQUEST AN AMENDMENT, YOUR REQUEST MUST BE MADE IN WRITING & SUBMITTED TO HOAG PELVIC HEALTH PROGRAM, OR CONTACT THE OFFICE FOR FURTHER INFORMATION. YOU MUST PROVIDE US WITH A REASON THAT SUPPORTS YOUR RQUEST FOR AMENDMENT.
5. RIGHT TO A COPY OF THIS NOTICE. YOU ARE ENTITLED TO RECEIVE A COPY OF THIS NOTICE OF PRIVACY PRACTICES. YOU MAY ASK US TO GIVE YOU A COPY OF THIS NOTICE AT ANY TIME. TO OBTAIN A COPY OF THIS NOTICE, CONTACT OUR OFFICE.
6. RIGHT TO FILE A COMPLAINT. IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH OUR PRACTICE OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. TO FILE A COMPLAINT WITH OUR PRACTICE, CONTACT THE OFFICE FOR FURTHER INFORMATION. ALL COMPLAINTS MUST BE SUBMITTED IN WRITING. YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.
7. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES. HOAG PELVIC HEALTH PROGRAM WILL OBTAIN YOUR WRITTEN AUTHORIZATION FOR USES AND DISCLOSURES THAT ARE NOT IDENTIFIED BY THIS NOTICE OR PERMITTED BY APPLICABLE LAW. IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OR OUR HEALTH INFORMATION PRIVACY POLICIES, PLEASE CONTACT HOAG PELVIC HEALTH PROGRAM.

I HEARBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF HOAG PELVIC HEALTH PROGRAM PRIVACY PRACTICES

PRINT NAME: _____
PATIENT SIGNATURE: _____DATE:_____

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INFORMED CONSENT FOR PHYSICAL THERAPY

Physical therapy is the art and science of physical/corrective rehabilitation for a wide variety of conditions, diseases, or injuries. It includes examination, evaluation, diagnosis, prognosis, and interventions through the use of various treatment techniques including joint mobilizations, soft tissue mobilization and myofascial release, massage, therapeutic exercise, neuromuscular re-education, patient education, and modalities such as heat/ice, electrical stimulation, and ultrasound. Physical therapy practice also includes consultation, promotion, and maintenance of physical fitness, health, and wellness through physical therapy interventions and education. **Informed consent** means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. Given each individuals presenting condition there is a variety of physical therapy services and interventions that may be included in your care and will be explained to you by your physical therapist during the initial evaluation.

Every individual responds differently to physical therapy interventions, and it is therefore difficult to predict your response to any one treatment technique or procedure. **HOAG PELVIC HEALTH PROGRAM** cannot guarantee that treatment will resolve or improve your condition or can guarantee that you won't have a negative reaction to treatment. Prior to your consent to treatment, your physical therapist will discuss their opinion on the potential results and anticipated outcomes given the various treatment techniques and procedures to be provided.

Potential benefits include but not limited to: Decrease in pain and symptoms, improvement in function, strength, flexibility, endurance, awareness, and greater knowledge and ability to manage presenting condition.

Potential risks may include: Increase or aggravation of pain or presenting symptoms, and may cause injury. Most aggravation or increased pain is temporary and can be discussed with your physical therapist.

You have the right to decline any part of treatment at anytime for any reason. It is your right to ask your physical therapist questions regarding any part of your care and to discuss the potential risks and benefits specific to your treatment plan. It is your right to decline participating in the physical therapy program presented. Alternatives to physical therapy can be discussed including returning to your physician for other treatment options.

I have read and understand all of the information above and consent to physical therapy evaluation and treatment. I agree to fully cooperate, participate, and comply with the established plan of care.

PRINT NAME: _____ **DATE**: _____

PATIENT SIGNATURE: (if minor, parent or legal guardian must sign) _____