Chittenango Physical Therapy

Name:________________________________ Date of Birth:______/______/______

SS Number:__________________________

Address:____

City State Zip

Primary Phone Number:____________Secondary Phone Number:_______________

E-Mail Address:______________________________

Appointment Reminders:

☐ Yes, please **call** my phone the day before to remind me Phone:_________________

☐ Yes, please send me a **text** message the day before to remind me Phone:_________________

Emergency Contact:____________________ Contact Phone Number:______________

Referring Doctor:__________________________

Primary Insurance:____________________Secondary Insurance:_________________

(Please present your insurance card(s) to the receptionist - Thank you!)

Where did you hear about Chittenango Physical Therapy?

Family/Friend Print Ad Doctor Website Online Search Insurance Radio Other:________________

Designated Individuals Authorization (Optional)

List anyone you would like Chittenango Physical Therapy to be able to correspond with about your care.
(Example: Family Members, Parents, Siblings, Spouse, Lawyer, Caregiver etc.)

I hereby authorize one or all of the designated parties below to request and receive any of my protected health information regarding treatment, payment or administrative operations. I understand that the identity of these designated parties will be verified before the release of any information.

Authorized Designees:

Name:__________________________ Relationship:________________________

Name:__________________________ Relationship:________________________

Name:__________________________ Relationship:________________________

____

Patient Signature

____

Date

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

Your protected health information will be used by Chittenango Physical Therapy or disclosed to others only for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Prior to signing this form, you may review the full Notification of Privacy PRactices for a more detailed description of how your protected health information may be used or disclosed.

I have been notified of the Privacy Practices for Chittenango Physical Therapy.

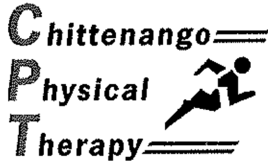
____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

Signature of Patient Representative:_____________________________________
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient



FAX: 315-510-3688
PHONE: 315-510-3372
1398 State Route 5
Chittenango, NY 13037

Pelvic Floor Examination Consent

A Thorough and complete examination of the pelvic floor region by a trained physical therapist may involve both internal and external assessment of the pelvic floor muscles and function. Patient comfort is a priority and a patient reserves the right to stop the examination or treatment at any time by verbally communicating to the treating therapist that they are no longer comfortable and would like to stop.

Patients reserve the right to have a spouse/partner or other family member present at the time of initial examination or during any treatment session if wanted. You may also request that another faculty member be present (PT aides will be available to assist during pelvic floor therapy treatments as needed).

CONSENT: I Consent to both internal and external examination of the pelvic floor region during physical therapy evaluation and subsequent treatment sessions.

Patient Signature:_______________________________________ Date:_____________

Verbal consent will also be attained by the treating therapist prior to internal examination or assessment.

Medical History- Do you have any of these conditions? (Male & Female)

NEUROLOGICAL
- ☐ Stroke
- ☐ Tia (Mini strokes)
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Dementia
- ☐ Seizures
- ☐ Peripheral neuropathy
- ☐ Pudendal neuralgia

MENTAL HEALTH
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Anxiety disorder
- ☐ PTSD
- ☐ Insomnia
- ☐ OCD
- ☐ Abuse/Trauma

HEARING
- ☐ Hard of hearing

DERMATOLOGICAL
- ☐ Psoriasis
- ☐ Eczema

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart disease
- ☐ Congestive heart failure
- ☐ Angina
- ☐ Heart attack
- ☐ Cardiac/defibrillator
- ☐ Vascular disease

HEMATOLOGICAL/IMMUNE
- ☐ Anemia
- ☐ Sickle cell
- ☐ Vitamin deficiency
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Auto-immune

RESPIRATORY
- ☐ COPD/emphysema
- ☐ Bronchitis
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Seasonal allergies

ENDOCRINE
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

DIGESTIVE
- ☐ Acid reflux/GERD
- ☐ Diverticulosis
- ☐ Constipation
- ☐ Chronic diarrhea
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease
- ☐ Celiac disease
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Hemorrhoids
- ☐ colostomy/Ileostomy

UROLOGICAL
- ☐ Overactive bladder
- ☐ Urinary incontinence
- ☐ Interstitial cystitis
- ☐ Bladder pain syndrome
- ☐ Bladder infections (UTI'S)
- ☐ Kidney disease
- ☐ Stones

MUSCULOSKELETAL
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Tailbone/pelvis trauma
  - ☐ Trauma from vehicle accident
  - ☐ Trauma from recent or past fall
- ☐ Diastasis Recti
- ☐ Sciatica
- ☐ Stenosis
- ☐ Scoliosis
- ☐ Herniated disc
- ☐ Degenerative discs
- ☐ Fracture:____________________
- ☐ Sprain:_____________________
- ☐ Low back pain
- ☐ Hip pain

FEMALE-OBSTETRICAL

# of pregnancies:_______________
# of vaginal deliveries:__________
# of C-sections:________________
# of miscarriages:______________
# of abortions:_________________
Weight of largest baby:_________lbs
Oldest child:______Youngest:______

- ☐ Vaginal tear
- ☐ Episiotomy
- ☐ Assisted delivery(Forceps, suction)

Are you currently pregnant?
- ☐ No
- ☐ Yes: how many weeks?________
  Due date:________________
- ☐ I'm currently breastfeeding

FEMALE-GYNECOLOGICAL
- ☐ Endometriosis
- ☐ Vulvodynia
- ☐ Vaginismus
- ☐ Yeast Infections
- ☐ Ovarian cysts
- ☐ Uterine fibroids
- ☐ Infertility
- ☐ Dyspareunia (painful intercourse)
- ☐ Fallen Bladder(cystocele)
- ☐ Fallen rectum(rectocele)
- ☐ Uterine or vaginal vault prolapse
- ☐ Currently use a pessary
- ☐ Hysterectomy-reason
  - ☐ Prolapse
  - ☐ Cancer
  - ☐ Pelvic Pain
  - ☐ Fibroids
  - ☐ Heavy Bleeding
  - ☐ Other:______________
- ☐ Heavy or irregular periods
- ☐ Menstrual pain
- ☐ Peri-menopausal
- ☐ Post-menopausal

MALE=PROSTATE
- ☐ Enlarged Prostate
- ☐ Prostate infections
- ☐ Chronic Prostatitis
- ☐ Prostate Pain
- ☐ Achieving erection
- ☐ Maintaining erection
- ☐ Difficulty with ejaculation
- ☐ erectile/ejaculation pain
- ☐ infertility

CANCER
- ☐ Type:____________________
- ☐ Treatment:________________

Do you have any of these symptoms? (Male & Female)

GENERAL BODY SYMPTOMS
- ☐ Fever, chills, night sweats
- ☐ Weight changes
- ☐ Unexplained pain
- ☐ Excessively chronically tired
- ☐ Dizziness, fainting
- ☐ Trouble sleeping

SKIN, HAIR, AND NAILS
- ☐ Dry Skin, Itching, rash
- ☐ Irregularly shaped moles
- ☐ Unexpected bruising
- ☐ Unexpected hair loss
- ☐ Changes in nail appearance

NERVES AND MEMORY
- ☐ Headaches
- ☐ Tingling, numbness
- ☐ Forgetfulness, confusion
- ☐ Trouble concentrating

MOOD AND FEELINGS
- ☐ Anxiousness, nervousness
- ☐ Sadness, hopelessness
- ☐ Lost of interests/purpose
- ☐ Wanting to die

EYES AND VISION
- ☐ Drooping eyelids

EARS, NOSE, MOUTH, AND THROAT
- ☐ Swollen glands
- ☐ Dry mouth

HEART AND VESSELS
- ☐ Chest pain
- ☐ Racing heart
- ☐ Dizziness upon standing
- ☐ Swelling in feet or hands

LUNGS AND BREATHING
- ☐ Chest Pain
- ☐ Shortness of breath
- ☐ Frequent coughing/sneezing
- ☐ Bloody Phlegm

STOMACH AND DIGESTION
- ☐ Indigestion/heartburn
- ☐ Nausea, vomiting
- ☐ Change in appetite
- ☐ Stomach Pain, Cramping
- ☐ Bloating

BOWELS AND DEFECATION
- ☐ Constipated
- ☐ Diarrhea
- ☐ Fecal Leakage
- ☐ Incomplete emptying of bowels
- ☐ Feeling of rectal obstruction
- ☐ Changes in stool color/formation
- ☐ Effortful bowel movements
- ☐ Painful bowel movements
- ☐ Rectal or tailbone pain

BLADDER AND URINATION
- ☐ Urine leakage
- ☐ Strong, sudden urges to void
- ☐ Bladder or urethral pain
- ☐ Pressure, burning sensations
- ☐ Frequent toilet visits
- ☐ Incomplete bladder emptying
- ☐ Urine stream changes
- ☐ Weak urine stream

GENITALS
- ☐ Pain, itching or burning
- ☐ Redness or white patches
- ☐ Feeling of warmth
- ☐ Feeling of coldness
- ☐ Lumps or wounds
- ☐ Change in libido/sexual respose
- ☐ Genital pain with sitting
- ☐ Pain during or after sex

FEMALE REPRODUCTIVE
- ☐ Vaginal dryness
- ☐ Clitoris or vaginal pain
- ☐ Pelvic pressure or pain
- ☐ Falling out feeling
- ☐ Vaginal bulge
- ☐ Difficult pregnancy or labor

MALE REPRODUCTIVE
- ☐ Erectile issues
- ☐ Tip or shaft or penis pain
- ☐ Scrotal or testicle pain
- ☐ Perineal pain
- ☐ Prostate pain

SPEECH AND SWALLOWING
- ☐ Voice or speech changes
- ☐ Word finding difficulties

MUSCLE AND BONES
- ☐ Diffuse muscle aches
- ☐ Muscle tightness
- ☐ Muscle spasm
- ☐ Tremors
- ☐ Shaking
- ☐ Lake of coordination
- ☐ arm/leg weakness
- ☐ Hand or finger weakness
- ☐ Poor posture
- ☐ Joint stiffness
- ☐ Joint swelling

STABILITY AND BALANCE
- ☐ Falls-current or history of
- ☐ Near falls
- ☐ Fear of falling
- ☐ Stumbling legs give away
- ☐ Unsteadiness
- ☐ Tripping over feet/toes

DIFFICULTY WITH:
- ☐ Using toilet
- ☐ Sitting
- ☐ Getting out of bed
- ☐ Standing up
- ☐ Walking
- ☐ Using stairs
- ☐ Running or jumping
- ☐ Exercising for health
- ☐ Taking care of a loved one
- ☐ Work/school performance
- ☐ Driving a vehicle

Are you currently exercising?

If so, what type:____________________

How often:____________________

Where are you exercising?

____

Intensity:
- ☐ High
- ☐ Medium
- ☐ Low

Height:________ Weight:________

Other Symptoms:

____

____

____

Bladder Function: Do you have a urologist? ☐ YES ☐ NO If yes, who?________________________

Daytime Urinary Frequency
How often do you urinate?
☐ More than every 8 hours
☐ Every 7-8 hours
☐ Every 6-7 hours
☐ Every 5-6 hours
☐ Every 4-5 hours
☐ Every 3-4 hours
☐ Every 2-3 hours
☐ Every 1-2 hours
☐ Every 30-60 min
☐ Less than every 30 min

Nighttime Urinary Frequency
After you have fallen asleep, how often do you urinate?
☐ 0-1 times
☐ 2 times
☐ 2-3 times
☐ 3 times
☐ 3-4 times
☐ 4 times or more

Urinary Leakage Frequency
How often do you accidentally leak urine?
☐ Never
☐ 1 time or less per month
☐ A few times a month
☐ a few times per week
☐ 1-2 times per day
☐ A few times a day
☐ Several times a day

Urinary Leakage Severity
How much urine leaks out when you accidentally lose urine?
☐ N/A
☐ a few drops
☐ a very small leak
☐ small leak
☐ medium leak
☐ Large leak
☐ Entire bladder contents

Protective Padding
What type of protective padding do you use for bladder control?
☐ N/A - none needed
☐ Change underwear
☐ Folded tissue paper
☐ Panty liner
☐ Thin pad
☐ Thick pad
☐ Diaper

Quantity Padding is Changed
How often do you change your protection?
☐ N/A-none needed
☐ Only when I leave the house
☐ Only during a cold or when I exercise
☐ 1 per day
☐ 2 per day
☐ 3 per day
☐ 4 per day
☐ 5 or more times per day

Padding Saturation
How saturated does your padding get?
☐ N/A no leakage
☐ "near miss"
☐ a few drops
☐ damp
☐ wet
☐ soaked
☐ overflow onto clothes

Urge Delay Ability
How long can you typically delay an urge to urinate?
☐ more than 5 hours
☐ 4-5 hours
☐ 3-4 hours
☐ 2-3 hours
☐ 1-2 hours
☐ 30-60 min
☐ 20-30 min
☐ 10-20 min
☐ 5-10 min
☐ a few minutes
☐ I go as soon as I feel an urge

Urgency Triggers
Do you ever have difficulty controlling urges to urinate with the situations listed below?
☐ No urge triggers
☐ around running water
☐ feeling cold
☐ feeling anxious or nervous
☐ Entering the house
☐ waiting too long/rushing to toilet

Urge Intensity
How would you rate the intensity of your urges to urinate?
☐ **Absent**- I don't feel urges to void at all.
☐ **Low**-I don't feel strong urges and I might have to remind myself to use the toilet.
☐ **Normal**- urges are controllable and I can urinate when it is convenient.
☐ **High**- I often feel strong urges that make me stop when I'm doing and rush to the toilet.
☐ **Leakage**- I feel strong urges and leak urine before I make it to the toilet.

Incontinence Precipitating Factors
If you experience accidental or unplanned losses of urine, when does it occur? Check all that apply.
☐ Coughing, sneezing, laughing
☐ Getting out of bed, chair, or car
☐ Bending reaching, kneeling or squatting
☐ Standing or walking around for awhile
☐ Running, jumping, or other strong exertions
☐ During sexual activity
☐ Approaching the toilet with an urge to urinate
☐ Pulling down pants to use toilet
☐ Around running water
☐ Feeling cold, nervous, or anxious
☐ Entering the house
☐ Waiting too long/rushing to the toilet

Urine Stream Quality: Do you ever notice any of the following symptoms when you are urinating?					
	Never	Rarely	Occasionally	Sometimes	Usually
Weak or slow urine stream					
A urine stream that splits or sprays					
A "stop and start" flow					
A slow start or hesitant urine stream					
A slow to finish or dribbled urine stream					
A dribble or leak after you feel you finished urinating?					
Effort to Empty Bladder: In order to start, maintain, or finish urinating, do you ever:					
Have to strain or bear down?					
Have to push over the bladder or lower abdomen?					
Have to change positions on the toilet? (lean, rock)					
Have to push upwards on genitals?					
Have to reposition the bladder with your hand or fingers?					
Have to use a catheter?					
Have a feeling of incomplete bladder emptying?					

Fluid Intake Habits- How many 8 ounce servings (cups) of the following fluids do you drink?

Type	Per Day	Per week	On Occasion	Never	Type	Per Day	Per Week	On Occasion	Never
Coffee ☐ reg ☐decaf					Milk				
Tea ☐ reg ☐decaf					Water				
Soda ☐ reg ☐decaf					Juice:_____				
Beer/liquor/wine					Other:_____				

Fluid avoidance	Urge avoidance	Medication avoidance	Activity avoidance
How often do you avoid drinking enough fluid in order to help with other bladder symptoms? ☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ Always	How often do you urinate before you feel urges to void, "just in case"? ☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ Always	How often do you avoid taking medication (diuretics) to help with bladder symptoms? ☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ Always	How often do you avoid exercise or exertional activity due to bowel symptoms? ☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ Always