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:_________________________

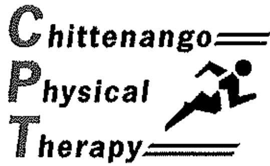
Name:___________________________ Relationship:_________________________

____

Patient Signature

____

Date



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.

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

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:

____

____

____

Bowel Function: Do you have a gastroenterologist? ☐ YES ☐ NO If yes, who?______________

Bowel Movement (BM) Frequency	Bowel Movement Urge Delay Ability	Bowel movement Urge Intensity
How often do you have a bowel movement? ☐ Less than once a month ☐ A few times a month ☐ Every 6-7 days ☐ Every 4-5 days ☐ Every 2-3 days ☐ Once a day ☐ 2-3 times a day ☐ 3-4 times a day ☐ 4-5 times a day ☐ 5-6 times a day ☐ 7 or more times a day ☐ I don't go for several days, then go multiple times in a day	How Long can you typically delay an urge to have a bowel movement? ☐ 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 mint ☐ A few minutes ☐ I go as soon as I feel an urge	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.
Stool Consistency	**Gas Control**	**Fecal Leakage Frequency**
How would you describe your stool formation? Check all that apply. ☐ Watery Diarrhea ☐ Loose and unformed ☐ Loose but formed ☐ Soft and formed ☐ Hard and formed ☐ Hard, rocky, pellet-like	How well are you able to control gas or flatulence during a social situation? ☐ Never ☐ Rarely ☐ Occasionally ☐ Sometimes ☐ Often ☐ Always	How often do you accidentally leak or lose fecal matter? ☐ Never ☐ 1 time or less per month ☐ A few times a month ☐ A few times a week ☐ One or two times a day ☐ A few times a day ☐ Several times a day
Fecal Leakage Severity	**Protective Padding**	**Quantity padding is changed**
How much fecal matter do you lose during an accident? ☐ N/A ☐ Staining or soiling ☐ Very small amount ☐ Small amount ☐ Medium amount ☐ Large amount ☐ Entire bowel contents	What type of protective padding do you use for bowel control? ☐ N/A- none needed ☐ Change underwear ☐ Folded tissue paper ☐ Panty liner ☐ Thin pad ☐ Thick pad ☐ Diaper ☐ Vinyl or plastic underpants	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

Fecal Incontinence Precipitating Factors	
If you experience accidental or unplanned losses of fecal matter or of flatulence, when does it occur? Please 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