

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:

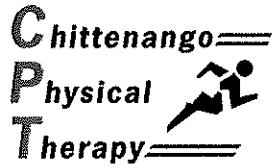
Name: _____ Relationship: _____

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 DEFECACTION

- 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 response
- 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
- Lack 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:

Pelvic Pain Symptoms

Bladder Pain

At its worst, circle how severe your bladder pain is: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

Occurrence: As my bladder fills When I urinate After I'm finished urinating

Location: Bladder Urethra Abdomen

Bowel Pain

At its worst, circle how severe your bowel pain is: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

Occurrence: As my bowels fill When I have a bowel movement After I am finished with a bowel movement

Location: Rectum Abdomen

Pain with Sexual Activity

At its worst, circle how severe your sexual pain is: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

Occurrence: Genital touching Penetration Thrusting Orgasm

For how long: Only during sexual activity For a few hours afterwards For a day or more afterwards

External Pelvic Pain (pelvic girdle pain)

Pain location:

Front of pelvis (anterior) Abdomen Inner thigh Side/waist Front of hips Over surgical scars

Back of pelvis (posterior) Low back Buttocks Groin Back of hips Side of hips

Bottom of pelvis (crotch) Urethra Bladder Rectum Genitals Tailbone

At its worst, circle how severe your pelvic pain gets: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

Mobility, Self-care and Domestic Functions

My pelvic pain symptoms affect my ability to, OR I feel worse when I:

Changing position

- Roll over
- Sit up
- Stand up
- Squat or kneel down
- Bend forward

Maintaining a Position

- Lie still
- Sit still
- Stand still

Moving Objects

- Push or pull something
- Reach or grasp for something
- Lift or carry something

Walking and Moving

- Walk short distances (home)
- Walk long distances (public)
- Walk outside/uneven surfaces
- Climb stairs or curbs
- Exercise movements

Taking care of myself Domestic Life

- Eat or drink certain foods
- Bath myself
- Take clothes/shoes on/off
- Wear tighter clothes
- Get comfortable
- Sleep soundlessly
- Exercise
- Have a medical exam
- Prepare meals
- Do dishes
- Do Laundry
- Do housework
- Do yard work
- Run errands
- Drive or sit in a car
- Provide care for a loved one

Relationship, Work, Social, and Recreation Participation Limitations:

Because of my pelvic problem, I am less likely to:

- Leave my house
- Go to unfamiliar places
- Travel 30 min or more from home
- Visit with friends or family the way I'd like
- Be intimate with someone
- Perform well at my job
- Join a club or volunteer
- Go to church or worship
- Go to a movie or a show or social event
- Exercise the way I should