PATIENT INFORMATION AND HISTORY FORM

PATIENT NAME: FIRST_____MI____LAST_____ Date of Birth: __/__/____

PHONE #'s (HOME): _____ (CELL): _____ Preferred #: (CIRCLE) HOME CELL

ADDRESS: _____

EMERGENCY CONTACT: _____ Relationship:_____PHONE#: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

DIAGNOSIS (CHIEF COMPLAINT/SYMPTOMS): _____

MEDICAL HISTORY:

A: Past surgical procedures: _____

_____

B: Have you had any Physical Therapy this year: YES NO

If so, for what, where, and how long? _____

C: Do you have, or have you ever had any of the following? Please circle

Heart attack	High blood pressure	Hemorrhoids	C-Section
Heart Failure	Cancer (type_____)	Asthma/COPD	Joint Replacement (where?_____)
Heart disease	Pacemaker	Sleep Apnea	Headaches/Migraines
Stroke	HIV/AIDS	Peptic Ulcers	Irritable Bowel Syndrome
Epilepsy	Hepatitis	TMJ pain	Pelvic Pain
Emphysema	Gall Bladder Trouble	Thyroid Issues	Depression/Anxiety
Diabetes	Osteoporosis/penia	Fibromyalgia	Low Back Pain
Arthritis	Rheumatoid Arthritis	Hearing Loss	Tailbone/Sacroiliac Pain

Please list any other conditions not mentioned _____

D: Drug Allergies: _____

E: Current Medications (list dose and frequency): _____

_____

F: Do you smoke? YES NO #years _____ #packs/day _____ Quit (date)? _____

G: Are you pregnant? YES NO Could you be? YES NO

H: What type of work do you do? _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned do hereby agree and give my consent for Coastal Therapy Services, Inc. to furnish necessary medical care and treatment to (patient name) _____.

PATIENT/GUARDIAN _____ DATE _____

BENEFIT ASSINGMENT AND RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including private insurance and any other health plans to Coastal Therapy Services, Inc. A photocopy of this original is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical records to secure payment.

PATIENT/GUARDIAN _____ DATE _____

FINANCIAL POLICY STATEMENT

Our policy is to bill your insurance carrier as a courtesy to you, however, you are responsible for the entire bill when the services are rendered. We require that payment of your estimated share be made at the time services are provided. If your insurance carrier does not remit payment within 90 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit.

If any payment is made directly to you for services billed by Coastal Therapy Services, Inc., it is your obligation to remit this payment to Coastal Therapy Services.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Coastal Therapy Services, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Estimated Insurance Benefits: _____

Estimated Patient Payment %: _____

NOTE: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

PATIENT/RESPONSIBLE PARTY: _____ DATE _____

NOTICE OF PATIENT INFORMATION PRACTICES

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU MAY HAVE ACCESS TO INFORMATION.

COASTAL THERAPY SERVICES, INC.'S LEGAL DUTY

Coastal Therapy Services, Inc., by law, must protect your personal health information, supply this notice about our information practices and follow the information practices described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Coastal Therapy Services uses your personal health information for treatment, obtaining payment for treatment, maintaining communication with your referring physician, conducting internal administrative activities and evaluating the quality of care that we provide.

Coastal Therapy Services, Inc, May also use or disclose your personal health information without prior authorizarion for public health purposes, for auditing purposes, for research and for emergencies. We also provide personal health information when required by law.

In any other situation, Coastal Therapy Services policy is to obtain your written authorization before disclosing your personal health information . If you provide us with a written authorization to release your information for any reason you may later revoke that authorization to stop future disclosures at any time.

Coastal Therapy Services may change its policy at any time. When changes are made a new Notice of Information Practices will be posted and/or provided to at you next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any innaccurate or incomplete informationn in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other realted administrative purposes.

You may request in writing that we not use or disclose your personal health information for treatment payment and administrative purposes except when specifically authorized by you, in an emergency, or when required by law. Coastal Therapy Services will consider all such requests, but is not required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Coastal Therapy Services may have violated your privacy rights, please contact Ashley Harrington, Privacy Officer, at 910-269-9110, or at PO Box 10511, Southport, NC 28461.

I HAVE READ AND AGREE WITH THE ABOVE STATEMENTS

_____ _____

Signature Date

PATIENT NAME: _____ DOB: _____ DATE: _____

Bowel and Bladder Habits

1. How often do you have a bowel movement? _____
2. How often do you have involuntary loss of bowels? _____
3. Are you constipated? NEVER RARELY SOMETIMES FREQUENTLY ALWAYS
4. Do you PUSH/STRAIN to have Bowel Movement? NEVER SOMETIMES FREQUENTLY ALWAYS
5. Do you have Diarrhea? NEVER RARELY SOMETIMES FREQUENTLY ALWAYS
6. How would you describe your Bowel movements? (use the scale below), you may indicate several

_____

BRISTOL STOOL SCALE

Type 1 Separate hard lumps, like nuts	**Type 2** Sausage-shaped but lumpy	**Type 3** Like a sausage but with cracks on its surface	**Type 4** Like a sausage or snake, smooth and soft	**Type 5** Soft blobs with clear-cut edges	**Type 6** Fluffy pieces with ragged edges, a mushy stool	**Type 7** Watery, no solid pieces, entirely liquid
						

7. Do you use
   a. Laxatives? Yes No How often? _____ What kind? _____
   b. Stool softeners? Yes No How often? _____ What kind? _____
   c. Fiber supplements? Yes No How often? _____What kind? _____
   d. Enemas? Yes No How often? _____ What kind? _____
8. How many times do you wake up at night to urinate? _____
9. How often do you use the bathroom during the day?
   Every… 30-60 minutes 1-2 hr 2-3 hr 3-4 hr 4+ hr Other: _____
10. Do you have urinary urgency (a strong urge to urinate)? YES NO
11. Do you ever leak urine? YES NO
12. Do you ever leak urine on the way to the restroom? YES NO
13. Do you ever find yourself damp or wet and not realize you have had an accident?
    Never Rarely Sometimes Often Always
14. Once your bladder feels full how long can you hold your urine?
    As long as I want A few minutes Less than a minute or 2 Cannot tell when bladder is full

PATIENT NAME: _____ DOB: _____ DATE: _____

15. **How often do each of the following lead to leakage?**

a. Running/Exercise	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Not able**
b. Sneezing/Coughing	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Not able**
c. Laughing	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Not able**
d. Lifting	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Not able**
e. Bending Down	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Not able**
f. Reaching	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Not able**
g. Sexual Intercourse	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Not able**
h. Changing position from lying, sitting, or standing up	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Not able**
i. Running Water or Flushing Toilet or washing hands	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Not able**

16. Circle any that apply when you try to urinate

a. **Difficulty starting flow of urine**
b. **Very slow stream or dribbling**
b. **Discomfort or pain**
d. **Blood in urine**
e. Leak/Dribble just after finishing
f. Feeling that bladder did not empty completely

17. How many glasses do you drink per day? Water? _____ Soda? _____

Coffee? _____ Wine? _____ Beer? _____ Liquor? _____

18. Do you have any PELVIC PAIN or LOWER ABDOMINAL PAIN? YES NO

If yes, WHERE?_____

Please rate the severity of your pain from 0-10 (0=NO pain, 10= VERY SEVERE)

Currently? _____ At its BEST? _____ At its WORST? _____ Most of the Time? _____

Describe your pain _____

_____

What makes it better? _____

What makes it worse? _____

How/When did the pain begin? _____

Do you have pain with intercourse? YES NO _____

Do you ever feel a sense of heaviness or pressure of the vagina or rectum? YES NO

How do you hope this therapy can help you? What are your goals? _____

_____

PATIENT NAME: _____ ACCT#: _____ DATE: _____

PELVIC FLOOR IMPACT QUESTIONNAIRE- SHORT FORM 7 (PFIQ-7)

INSTRUCTIONS: Some men and women find that bladder, bowel or pelvic symptoms affect their activities, relationships, and feelings. For each question place an **X** in the response that best describes how much your activities, relationships, or feelings have been affected by your bowel, bladder or pelvic symptoms or conditions **over the past 3 months**. Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions relating to the following (→→→) usually affect your ↓	**Bladder or urine**	**Bowel or rectum**	**Vagina, Penis, Pelvis or Perineum**
1. Ability to do household chores (cooking, housekeeping, laundry)?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
3. Entertainment activities such as going to a movie or concert?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes from home?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
5. Participating in social activities outside your home?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
6. Emotional health (nervousness, depression, etc.)?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
7. Feeling frustrated?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit

Urinary IQ= Colorectal-Anal IQ= Pelvic Organ Prolapse IQ=