
**2099 GRAND ISLAND BLVD.**
**Suite B**
**(716) 773-3300**

# Patient Information Form

Name: First: _____ MI: _____ Last: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: Male / Female E-mail Address: _____

Emergency Contact/Phone #: _____

Referring Physician: _____

Date of Injury: _____

***DO YOU HAVE AN OPEN WORKMAN'S COMP OR NO-FAULT CASE FOR THIS BODY PART? Y / N***

Describe in a ***FEW SHORT*** sentences your main reason for this appointment:

_____

_____

_____

**PRIMARY INSURANCE INFORMATION**

Insurance Company Name: _____

ID #: _____ Group #: _____

Name of Person Insured: _____ Relation: _____

Insured's Employer: _____ Insured Person's Date of Birth: _____


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# Medical History Form

**Name:** _____ **Age:** _____

**Please indicate if you have had or now have the following:**

| Condition | Y | N | Condition | Y | N |
|---|---|---|---|---|---|
| High blood pressure | | | Abdominal or Mid-Back Pain | | |
| Heart disease/attack, pacemaker | | | Open wounds | | |
| Cancer | | | Skin condition | | |
| Osteoarthritis | | | Metal implant/fragments | | |
| Rheumatoid arthritis | | | Osteoporosis | | |
| Diabetes | | | Vascular problems | | |
| Fracture | | | Neck or back problems | | |
| Stroke or TIA | | | Fever and chills | | |
| Infectious disease | | | Unexplained weight loss | | |
| Seizures/Epilepsy | | | Pregnant now | | |
| COPD, bronchitis, asthma | | | | | |
| Joint Replacements | | | | | |

If you marked yes above, please provide more information:

_____

_____

Please list all previous surgeries:

_____

_____

Please list all medications currently being taken (include all over the counter and herbal supplements):

_____

_____

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# Pelvic Floor Impact Questionnaire

Name: _____

Some people find that bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question circle the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions over the last 3 months. Please make sure you mark an answer in all 3 columns for each question.

| **How do symptoms or conditions relate to the following usually affect your** | **Bladder or Urine** | **Bowel or Rectum** | **Vagina or Pelvis** |
|---|---|---|---|
| 1. Ability to do household chores (cooking, housecleaning, laundry)? | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit |
| 2. Ability to do physical activities such as walking, swimming, or other exercise? | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit |
| 3. Entertainment activities such as going to a movie or concert? | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit |
| 4. Ability to travel by car or bus for a distance greater than 30 minutes away from home? | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit |
| 5. Participating in social activities outside your home? | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit |
| 6. Emotional health (nervousness, depression, etc.)? | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit |
| 7. Feeling frustrated? | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit | Not at All<br>Somewhat<br>Moderately<br>Quite A Bit |

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# Pelvic Floor Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have the physical therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from the attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the therapist if I am having any discomfort or unusual symptoms during the evaluation/treatment.
4. I have the option of having a second person to present in the room during the procedure and I choose to refuse this option.

Date: _____ Patient Name (please print): _____

_____ _____

Patient Signature Parent/Guardian Signature (if applicable)

_____

Witness Signature (if patient under 18)


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# Patient authorization for use and closure of protected health information and statement of privacy notice.

**We may disclose your health care information:**

1.To other health care professionals within our practice for the purpose of treatment, payment, or health care operations.

2. To your insurance provider for the purpose of payment or health care operations.

3. To comply with State Workers' Compensation laws.

4. To public health employees for preventing/controlling disease and reporting infectious exposures.

5. In the course of any administrative or judicial proceeding or law enforcement purposes.

**Under the HIPPA federal privacy law, you have the right to:**

1. Request restrictions on certain uses and disclosures of your health information.

2. Inspect and copy your health care information.

3. Receive an accounting or disclosures of your protected health information made by us.

4. Have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future.

We are required by law to maintain the privacy of your health information.

My signature indicates my authorization and consent for The P.T. Center to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described above.

**Patient's Name (please print)**

**Patient's Signature** **Date**

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# Cancellation Requirements

Please read and provide signature below

Pelvic Floor Therapy is a commitment to resolve issues which affect you in both physical and emotional ways.

**APPOINTMENT TIMES**: The appointment desk will do their best to accommodate patient requests, you may not always have the 5:00pm slot as this time period is rotated between patients.

**ATTENDANCE**: It is important that you try to attend all of your scheduled sessions.

**SAME DAY CANCELLATIONS WILL RESULT IN A $40.00 CANCELLATION FEE,** AS THIS IS AN ENTIRE HOUR OF ONE-ON-ONE TREATMENT.
***24 HOUR NOTICE IS REQUIRED TO AVOID THE FEE.*** *(We prefer 48 hours if possible.) Exceptions may be made if patient has a heavy menstrual cycle.*

OUR MAIN CONCERN AT THIS OFFICE **IS YOU**. We are here to assist you through your rehabilitation and looks forward to working together with you as a team.

Sign_____Date _____