

Riverwalk Physical Therapy, L.L.C.
PATIENT SUMMARY

Date _____

PERSONAL INFORMATION

Name _____ Date of Birth _____

Street Address _____ Age _____ Gender: Male Female

City _____ State _____ Zip _____

CONTACT INFORMATION

Cell Phone _____ Home Phone _____
(Parent/Guardian's # if patient under 18 years old)

Email _____ Work Phone _____
(automatic 24hr advance appointment reminders)

Parent/Guardian Name _____ Phone _____
(if patient under 18 years old)

Emergency Contact _____ Phone _____

Contact Relationship: Spouse Mother Father Sibling Child Guardian Other

MEDICAL HISTORY

Referring Physician _____ Location _____

Primary Care Physician _____ Location _____

Date of Injury _____ Date of Surgery (if applicable) _____

Date of next Physician visit _____

Please check the appropriate response	Yes	No
Is your current condition auto accident related?		
Is your current condition work related?		
Have you received or are you receiving physical, occupational, massage, chiropractic or pain management from any other facility or provider at this time? If yes, please explain		

Whom may we thank specifically for this referral?

Riverwalk Physical Therapy, L.L.C.
PELVIC FLOOR PATIENT HISTORY

Name _____ DOB _____ Age _____ Date _____

1. Describe the current problem that brought you here: _____

2. When did your problem first begin? _____ months ago OR _____ years ago.

3. Was your first episode of the problem related to a specific incident? Yes/No

Please describe and specify date: _____

4. Since that time is it: staying the same getting worse getting better

Why or how? _____

5. Rate the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10
None Worst Imaginable

6. If pain is present, rate the average intensity of the pain: 0 1 2 3 4 5 6 7 8 9 10
None Worst Imaginable

7. Describe the nature of the pain (i.e. constant burning, intermittent ache) _____

8. Date of Last Physical Exam _____ Tests performed _____

9. Describe previous treatment/exercises _____

10. How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify _____

Diet /Fluid intake, specify _____

Physical activity, specify _____

Work, specify _____

Other _____

11. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

- | | |
|--|--|
| <input type="checkbox"/> Sitting greater than _____ minutes | <input type="checkbox"/> With cough/sneeze/straining |
| <input type="checkbox"/> Walking greater than _____ minutes | <input type="checkbox"/> With laughing/yelling |
| <input type="checkbox"/> Standing greater than _____ minutes | <input type="checkbox"/> With lifting/bending |
| <input type="checkbox"/> Changing positions (ie. sit to stand) | <input type="checkbox"/> With cold weather |
| <input type="checkbox"/> Light activity (light housework) | <input type="checkbox"/> With triggers ie. running water/key in door |
| <input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump) | <input type="checkbox"/> With nervousness/anxiety |
| <input type="checkbox"/> Sexual activity | <input type="checkbox"/> No activity affects the problem |
| <input type="checkbox"/> Other, please list _____ | |

12. What relieves your symptoms? _____

13. What are your treatment goals/concerns? _____

14. Since the onset of your current symptoms have you had:

- | | |
|---|--|
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Malaise (unexplained tiredness) |
| <input type="checkbox"/> Unexplained weight change | <input type="checkbox"/> Unexplained muscle weakness |
| <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Night pain/sweats |
| <input type="checkbox"/> Change in bowel or bladder functions | <input type="checkbox"/> Numbness / Tingling |
| <input type="checkbox"/> Other /describe _____ | |

General Health: Excellent Good Average Fair Poor Occupation_____

Hours/week_____ On disability or leave?_____ Activity Restrictions?_____

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week

Describe _____

Mental Health: Current level of stress High Med Low Currently in psych therapy

Have you ever had any of the following conditions or diagnoses? Check/circle all that apply:

- Cancer
- Heart problems
- High Blood Pressure
- Ankle swelling
- Anemia
- Low back pain
- Sacroiliac/Tailbone pain
- Alcoholism/Drug problem
- Childhood bladder problems
- Depression
- Anorexia/bulimia
- Smoking history
- Vision/eye problems
- Hearing loss/problems
- Other/Describe_____
- Stroke
- Epilepsy/seizures
- Multiple sclerosis
- Head Injury
- Osteoporosis
- Chronic Fatigue Syndrome
- Fibromyalgia
- Arthritic conditions
- Stress fracture
- Acid Reflux /Belching
- Joint Replacement
- Bone Fracture
- Sports Injuries
- TMJ/ neck pain
- Emphysema/chronic bronchitis
- Asthma
- Allergies-list below
- Latex sensitivity
- Hypothyroid/ Hyperthyroid
- Headaches
- Diabetes
- Kidney disease
- Irritable Bowel Syndrome
- Hepatitis HIV/AIDS
- Sexually transmitted disease
- Physical or Sexual abuse
- Raynaud's (cold hands and feet)
- Pelvic pain

Surgical /Procedure History

- Surgery for your back/spine
- Surgery for your brain
- Surgery for your female organs
- Other/describe_____
- Surgery for your bladder/prostate
- Surgery for your bones/joints
- Surgery for your abdominal organs

Ob/Gyn History (Females only)

- Childbirth vaginal deliveries #_____
- Episiotomy #_____
- C-Section #_____
- Difficult childbirth #_____
- Prolapse or organ falling out
- Other/describe_____
- Vaginal dryness
- Painful periods
- Menopause - when? _____
- Painful vaginal penetration
- Pelvic

Males only

- Prostate disorders
- Shy bladder
- Pelvic pain
- Other/describe_____
- Erectile dysfunction
- Painful ejaculation

<u>Medications - pills, patch</u>	<u>Start date</u>	<u>Reason for taking</u>

<u>Over the counter - vitamins etc</u>	<u>Start date</u>	<u>Reason for taking</u>

Bladder / Bowel Habits / Symptoms Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Trouble initiating urine stream | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urinary intermittent /slow stream | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Trouble emptying bladder | <input type="checkbox"/> Trouble feeling bladder urge/fullness |
| <input type="checkbox"/> Trouble emptying bladder completely | <input type="checkbox"/> Current laxative use |
| <input type="checkbox"/> Difficulty stopping the urine stream | <input type="checkbox"/> Trouble feeling bowel urge/fullness |
| <input type="checkbox"/> Straining or pushing to empty bladder | <input type="checkbox"/> Constipation/straining _____% of time |
| <input type="checkbox"/> Dribbling after urination | <input type="checkbox"/> Trouble holding back gas/feces |
| <input type="checkbox"/> Constant urine leakage | <input type="checkbox"/> Recurrent bladder infections |
| <input type="checkbox"/> Other/describe _____ | |

1. Frequency of urination: awake hours _____ times per day, sleep hours _____ times per night
 2. When you have a normal urge to urinate, how long can you delay before having to go to the toilet? _____minutes, _____hours, _____not at all
 3. The usual amount of urine passed is: small medium large
 4. Frequency of bowel movements _____ times per day, _____times per week, or _____
 5. The bowel movements typically are: watery loose formed pellets other _____
 6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all
 7. If constipation is present describe management techniques _____
 8. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated? _____glasses per day.
 9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
 None present
 Times per month (specify if related to activity or your menstrual period)
 With standing for _____ minutes or _____ hours.
 With exertion or straining
 Other _____
-
- | | |
|--|---|
| 10a. Bladder leakage - number of episodes | 10b. Bowel leakage - number of episodes |
| <input type="checkbox"/> No leakage | <input type="checkbox"/> No leakage |
| <input type="checkbox"/> Times per day | <input type="checkbox"/> Times per day |
| <input type="checkbox"/> Times per week | <input type="checkbox"/> Times per week |
| <input type="checkbox"/> Times per month | <input type="checkbox"/> Times per month |
| <input type="checkbox"/> Only with physical exertion/cough | <input type="checkbox"/> Only with exertion/strong urge |
- 11a. On average, how much urine do you leak?
 No leakage
 Just a few drops
 Wets underwear
 Wets outerwear
 Wets the floor
 - 11b. How much stool do you lose?
 No leakage
 Stool staining
 Small amount in underwear
 Complete emptying
12. What form of protection do you wear? (Please complete only one)
 None
 Minimal protection (tissue paper/paper towel/panty shields)
 Moderate protection (absorbent product, maxi pad)
 Maximum protection (specialty product/diaper)
 Other _____

On average, how many pad/protection changes are required in 24 hours? _____# of pads

Patient or Parent/Guardian Signature _____ Date _____

Riverwalk Physical Therapy, L.L.C.

CONDITIONS & CONSENT FOR PELVIC FLOOR PHYSICAL THERAPY

_____ COOPERATION WITH TREATMENT:

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

_____ CANCELLATION POLICY:

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance or fail to come to a scheduled appointment, I will pay a cancellation fee of \$100.00.

_____ NO WARRANTY:

I understand that Riverwalk Physical Therapy, LLC and/or Zarina Vitebsky, MSPT cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that Zarina Vitebsky, MSPT will share with me her opinions regarding potential results of pelvic floor physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

INFORMED CONSENT FOR TREATMENT:

The term "informed consent" means that the potential risks, benefits, and alternatives of pelvic floor physical therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

_____ **Potential risks:** I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist, and my medical professional.

_____ **Potential benefits:** May include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

_____ **Evaluation and Treatment:** I understand I will be receiving an internal pelvic floor examination / treatments and will have the ability to speak with the therapist prior to my examination / treatments.

CONSENT TO LEAVE MESSAGES ON YOUR ANSWERING MACHINE (please initial one answer below):

YES Please leave me messages _____

NO Please do not leave me messages _____

I have read the above information and I consent to physical therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Patient Name (please print) _____

Patient or Parent/Guardian Signature _____ Date _____

Riverwalk Physical Therapy, LLC

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to the Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Financial Responsibility

I have requested professional services from RIVERWALK PHYSICAL THERAPY, LLC, ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advanced.

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: **RIVERWALK PHYSICAL THERAPY, 665 MARTINSVILLE ROAD, BASKING RIDGE, NJ 07920**. or If my current policy prohibits direct payment to Riverwalk Physical Therapy, LLC., I hereby also instruct and direct you to make out the check to me and mail it as follows: **RIVERWALK PHYSICAL THERAPY, 665 MARTINSVILLE ROAD, BASKING RIDGE, NJ 07920** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. If payment is mailed directly to me I will bring in the check and explanation of benefits within 1 week of receipt.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient or Parent/Guardian Signature _____ Date _____