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

☐ Sitting greater than_____ minutes
☐ Walking greater than _____minutes
☐ Standing greater than _____ minutes
☐ Changing positions (ie. sit to stand)
☐ Light activity (light housework)
☐ Vigorous activity/exercise (run/weight lift/jump)
☐ Sexual activity
☐ Other, please list_____

☐ With cough/sneeze/straining
☐ With laughing/yelling
☐ With lifting/bending
☐ With cold weather
☐ With triggers ie. running water/key in door
☐ With nervousness/anxiety
☐ No activity affects the problem

12. What relieves your symptoms?_____

_____

13. What are your treatment goals/concerns?_____

_____

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

☐ Fever/Chills
☐ Unexplained weight change
☐ Dizziness or fainting
☐ Change in bowel or bladder functions
☐ Other /describe_____

☐ Malaise (unexplained tiredness)
☐ Unexplained muscle weakness
☐ Night pain/sweats
☐ Numbness / Tingling

 Name _____

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

☐ Other/Describe_____

Surgical /Procedure History

☐ Surgery for your back/spine	☐ Surgery for your bladder/prostate
☐ Surgery for your brain	☐ Surgery for your bones/joints
☐ Surgery for your female organs	☐ Surgery for your abdominal organs

☐ Other/describe_____

Ob/Gyn History (Females only)

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

☐ Other/describe_____

Males only

☐ Prostate disorders	☐ Erectile dysfunction
☐ Shy bladder	☐ Painful ejaculation
☐ Pelvic pain	

☐ Other/describe_____

Medications - pills, patch	Start date	Reason for taking

Over the counter - vitamins etc	Start date	Reason for taking

 Name _____

Bladder / Bowel Habits / Symptoms Check all that apply:

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

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

10b. Bowel leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ 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 Mary Norey, DPT cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that Mary Norey, DPT 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_____