Patient Information Form

-Please Print-

PATIENT NAME______________________________________ DATE OF BIRTH______________________

ADDRESS___________________________________CITY_________________SATE_____ZIP____________

PHONE (   )_______-____________ WORK PHONE (   )______-_________ SEX: M F AGE: _________

IS IT OKAY TO LEAVE A MESSAGE ON THE PHONE NUMBER YOU PROVIDED? YES NO

DRIVERS LICENSE #______________________ HOW DID YOU HEAR OF US? _________________________

REFERRING PHYSICIAN ________________________________ PHYSICIAN'S PHONE (   )_____ - _________

EMERGENCY CONTACT_________________________________ RELATIONSHIP _______________________

EMERGENCY CONTACT'S PHONE (   ) _____-_____________

PRIMARY INSURANCE____

SECONDARY INSURANCE____

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT)

FULL NAME__________________________________

ADDRESS ___________________________________ CITY ________________ STATE ______ ZIP _______

EMPLOYER NAME__________________________________ EMPLOYER PHONE # _____________________

HAVE YOU HAD PREVIOUS PHYSICAL THERAPY, OCCUPATIONAL THERAPY, OR SPEECH THERAPY THIS CALENDAR YEAR? YES NO HAVE YOU HAD HOME HEALTH THERAPY? IF SO, WHEN? _____________

PLEASE CHECK THE CAUSE OF INJURY RELATED TO THIS APPOINTMENT (MUST PICK ONE)

☐ AUTO ☐ WORK ☐ HOME ☐ OTHER (PLEASE EXPLAIN)______________________________

IF YOU CHECKED AUTO OR WORK ABOVE, PLEASE COMPLETE THE FOLLOWING:

IS THERE LEGAL ACTION PENDING? YES NO

ATTORNEY'S NAME ________________________________ PHONE NUMBER ________________________

WORKER'S COMPENSATION CARRIER ___________________________ CLAIM NUMBER ______________

NAME OF ADJUSTER ________________________________ PHONE (   ) _____-__________

HUNTINGTON BEACH
PHYSICAL THERAPY
SPECIALISTS

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Incontinence and Pelvic Floor Patient Form

(Please fill out ONLY if you will be treated for Incontinence or pelvic floor)

How frequently do you urinate in a 24 hour period? ___________________________

How many incontinent voids (accident) in a 24 hour period? ____________________

How much urine loss occurs with and incontinent void? Small Medium Large (circle one)

Do you experience urine loss before reaching the toilet? ________________________
How often? ____________________

Do you leak urine when you (Please circle YES or NO):

Cough once?	YES NO	Have coughing spells?	YES NO
Sneeze once?	YES NO	Have a sneezing spell?	YES NO
Laugh?	YES NO	Jump?	YES NO
Run?	YES NO	Exercise?	YES NO
Walk?	YES NO	Bend over?	YES NO

Pick up an object? YES NO If yes, what is the weight of the object? ____________

When does urine loss most occur (circle one) DAY NIGHT BOTH
How much fluid do you drink during the day? ____________________
Do you drink caffeinated coffee, teas or sodas? __________Amount & Frequency ______________

What is the date of your last menses? ____
Have you ever been given hormone replacement therapy? (Date) ____________________________
Are you undergoing hormone replacement now? ____

Do you use panty liners, sanitary napkins, tissues, disposable briefs, or any other absorbent material for urine control? ____

Do you leak urine when you are nervous or excited? YES NO
Does urine escape from you when you raise or lower yourself from a chair? YES NO
Is it difficult to stop urine once it starts flowing? YES NO
Are you currently taking any medications? YES NO If yes, please list all medications on form attached

Have you had any previous surgeries? YES NO ____

Name (Please Print):____

Signature: ________________________________ Date: _______________

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History and Physical Condition Information

Name: ____ Age:______________

Referring Physician: ______________________________________

Primary Care Physician: ________________________________Phone: ________________

Problems to be treated: ____

____

____

Approximately when did your injury start? ____

____

Have you had treatment for this problem before? YES NO
If YES, state where:___________________________________ When ______________
Treatment given: ____

Have you had surgery associated with this problem? YES NO

What is your current height: ___________ current weight: _____________

Please list *all* medications on the separate *Medication list* form:

Do you now have / or have you ever had any of the following:

High Blood Pressure	YES	NO	Sensitive to Heat/Ice	YES	NO
Heart Disease	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Dizzy Spells	YES	NO
Kidney Problems	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO	Other Illnesses	YES	NO
Cancer	YES	NO	Describe__________________________		
History of Smoking	YES	NO	Are you pregnant?	YES	NO

If YES on any of the above, please explain and give approximate dates:________________

____
Have you had Physical Therapy before for any injury? YES NO If YES, when and for how long?_____

Please provide your intended goals for Physical Therapy involving your current injury.__________

____

____
The above information is correct to the best of my knowledge.

Signature: _______________________________________ Date: ____________

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Medication List

Required for all patients

PATIENT NAME__________________________________ DATE_______________

Name of Medication/Vitamins/Supplements	Dosage/Frequency	Purpose of Medication

(Attn: Medicare Patients: Due to new changes implemented by Medicare and CMS, we are asking you to please list all the medications, supplements, vitamins, and herbs that you currently take, along with their respective dosages, frequency and purpose. These new regulations have been implemented in an effort to improve quality care and reporting for all Medicare patients. Many medications and vitamins can affect your musculoskeletal system and informing us of them will help ensure the best possible treatment for you and your overall health.)

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Pain Scale

Required for all Patients

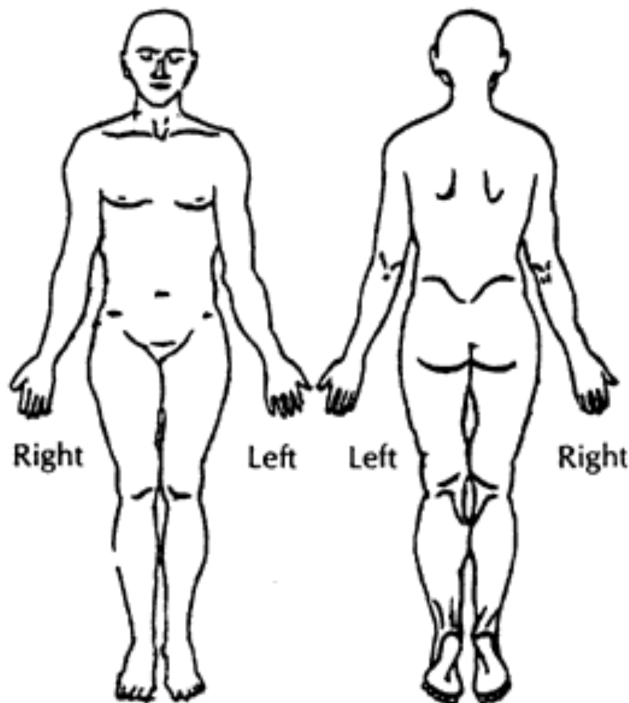
NUMERIC PAIN SCALE

PLEASE RATE YOUR PAIN ON THE FOLLOWING NUMBERIC SCALE, BY CIRCLING THE NUMBER WHICH BEST DESCRIBES YOUR PAIN.

0	1	2	3	4	5	6	7	8	9	10
Normal No Pain	Very Weak	Weak	Moderate		Somewhat Strong		Strong	Very Strong	Very Very	Emergency

THE PAIN DRAWING

Indicate your symptoms on the body diagrams using symbols in the key below.



//// Stabbing xxxx Aching 00000 Pins and needles ####Numbness

X_____________________________________

Patient Signature

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Fall Efficacy Scale

(Required for all **Medicare** patients only)

Patient Name ____ Date _______________

Pursuant to Medicare guidelines we are required to assess any risk for falls and provide an appropriate plan of care or advice for assistive device.

1. Have you had two or more falls in the past year? Yes No
   If YES, when? ____

2. Were there any injuries caused by these falls? Yes No
   If YES, in what area? ____

On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you do the following activities without falling?

Take a bath or shower

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

Reach into cabinets or closets

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

Walk around the house

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

Prepare meals not requiring carrying heavy or hot objects

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

Get in and out of bed

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

Answer the door or telephone

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

Get in and out of a chair

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

Getting dressed and undressed

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

Personal grooming (i.e. washing your face)

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

Getting on and off of the toilet

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

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Consent Form

Patient Name: ________________________________ If minor, parent/guardian name_______________

A photocopy of this document and signatures shall be considered as effective and valid as the original.

1. CONSENT FOR TREATMENT: I, the undersigned, hereby authorize Huntington Beach Physical Therapy Specialists and/or Tustin Physical Therapy Specialists (the "Clinic") to render services to me/patient, which are deemed necessary by the treating provider.

   X____

   Signature of Patient/Guardian Date

2. RESPONSIBILITY FOR PAYMENT: I, the undersigned, take full responsibility for payments for all services rendered by Provider. If I have insurance benefits available, I understand that my insurance is a contract between me and my insurance company and NOT between the provider and my insurance company, and that I will be solely responsible for all billing and collection from the insurance company for all services rendered. The Provider cannot guarantee that the insurance company will pay, even if the policy provides for coverage, or approval was previously granted. Payment is due when services are rendered unless previous arrangements have been provided.

   X____

   Signature of Patient/Guardian Date

3. CONFIDENTIALITY & PRIVACY OF PATIENT: I am aware that my medical information is confidential and may not be shared (except as permitted by law) with anybody without my consent. I am also aware that the staff at the Clinic may view my medical records for continuity of treatment.

   X____

   Signature of Patient/Guardian Date

4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I have read and fully understand the Clinic's Notice of Information Practices, the undersigned, consent to the use and disclosure of my personal health information for purposes as noted in the Clinic's Notice of Information and hereby authorizes the Provider and Staff to release information concerning my health acquired in the course of examination, history and treatment to a Physician, Healthcare provider and/or Insurance Carrier, as appropriate.

   X____

   Signature of Patient/Guardian Date

5. CANCELLATION POLICY: PLEASE GIVE 24 HOURS NOTICE IF YOU ARE UNABLE TO MAKE YOUR SCHEDULED APPOINTMENT. A $35 FEE WILL BE INCURRED FOR ANY CANCELLATIONS GIVEN WITHOUT 24 HOURS NOTICE

   AFTER TWO FAILED APPOINTMENTS WITHOUT NOTIFICATION, YOUR REMAINING APPOINTMENTS WILL BE TAKEN OFF THE SCHEDULE UNTIL YOU NOTIFY US BY TELEPHONE OR IN PERSON.
   I HAVE READ AND AGREE TO THE ABOVE APPOINTMENT & CANCELLATION POLICY.

   X____

   Signature of Patient/Guardian Date

6. SCHEDULING: In order to secure times that you desire, we recommend that you schedule at least two weeks of appointments, up to the length of your prescription, but it remains your choice to schedule future appointments and your responsibility to continue to schedule for the duration of your treatment.

   Please initial here _____________________________

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Urogenital Distress Inventory (UDI-6 Short Form): UDI-6

1) Do you usually experience frequent urination? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

2) Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

3) Do you usually experience urine leakage related to coughing, sneezing, or laughing? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

4) Do you experience small amounts of urine leakage (that is, drops)? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

5) Do you experience difficulty emptying your bladder? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

6) Do you usually experience pain or discomfort in the lower abdomen or genital region? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

   If yes, then is your pain relieved after emptying your bladder? ☐ Yes ☐ No

No= 0, Not at all= 1, Somewhat= 2, Moderately= 3, Quite a bit= 4
Add all scores and multiply by 6 then multiply by 25 for the scale score
Missing items are dealt with by using the mean from the answered items only
Higher score = higher disability
Also see scoring of PFDI-20.

Uebersax JS, Wyman JF, Shumaker SA, McClish DK, Fantl AJ. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and the urogenital distress inventory. *Neurourol and Urodynam* 1995;14:131-139.

Grade A rating for symptoms of UI for women
Donavan J, et al Symptom and quality of life assessment. In Incontinence vol 1 Basics and Evaluation eds Abrams P, Cardozo L, Khoury S, Wein A. Health Publications Ltd Paris France 2005.