Date

Date of Birth

Name

Employer

Address

Address

City, State, Zip

City, State, Zip

Work Telephone

Email:

Primary Care Physician

Referring Physician

Type of injury: Employer related______Auto accident______Home______Unknown______Other______

Date of injury/onset:________________

**Have you ever had physical therapy before? Yes_____No_____

If yes, during your Benefit Year of __________? Yes_____No_____ How many visits?_______

**Are you currently having home health care services of any kind? Yes _____ No _____

In case of emergency notify: Name______________________________Telephone(_______)________-____________

Attorney (if any)____Telephone(______)________-______________

Insurance Company

Secondary Insurance (if any)

Subscriber (name of cardholder)

Subscriber (name of cardholder)

Subscriber Date of Birth

Subscriber Date of Birth

Policy or Claim # Group #

Policy or Claim # Group #

Subscriber's Address if Different From Patient

Subscriber's Address if Different From Patient

**Who will be responsible for any expenses not covered by insurance? ________________________________

****

(PLEASE PROCEED TO NEXT PAGE)

PLEASE READ THE FOLLOWING CAREFULLY
THEN INITIAL, SIGN AND DATE BELOW

CANCELLATION AND NO SHOW POLICY

AFTER TWO "NO-SHOWS", THE REMAINDER OF YOUR APPOINTMENTS WILL BE CANCELLED. 24 HOUR NOTICE IS REQUIRED FOR CANCELLATION. MULTIPLE CANCELLATIONS WILL RESULT IN THE TERMINATION OF THERAPY.

Initial_______

INSURANCE REFERRALS/AUTHORIZATION

I understand that if I am a member of a private health insurance that requires referrals and or authorization for physical therapy that for each treatment for which I do not have a referral or authorization to be seen, I will be responsible for payment for services rendered should these treatments be denied by my health insurance carrier.

****IF YOU HAVE AN HMO OR MEDICARE YOUR BENEFIT IS LIMITED. ****
PLEASE ASK FOR DETAILS.

Initial________

PATIENT BILL OF RIGHTS

I have been provided a copy of the Patient Bill of Rights or have chosen to read the copy posted in the waiting area. I understand my rights as a patient outlined in this document.

Initial_______

ELIGIBILITY AND BENEFITS

It is the responsibility of the patient or responsible party to confirm their eligibility and benefits with their health carrier. You are responsible for contacting your insurance carrier to establish what your individual benefit is for services rendered. As a courtesy, Harmeling Physical Therapy and Sports Fitness, Inc. (hereafter Harmeling PT) checks eligibility and benefits on all patients however we cannot be held responsible for misquoted benefits.

Initial________

FINANCIAL RESPONSIBILITY

I understand that I and/or my family are responsible for all services rendered by Harmeling PT. I further understand that I am financially responsible for, and agree to pay, all deductibles, as well as any copays and/or other co-insurance not covered by my or my dependent's insurance carrier.

Copay payments will be collected upon arrival at each treatment.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize payment of all medical benefits directly to Harmeling PT, to include major medical benefits to which I, or my dependents, am entitled including Medicare and other government sponsored programs, private insurance and any other health plans for all charges incurred by me or my dependent. I hereby authorize Harmeling PT to release any and all information necessary to secure payment of said benefits.

RELEASE OF INFORMATION

I hereby authorize Harmeling PT to disclose or obtain all or any part of my, or my dependent's record, to or from any person or corporation which may be liable for all or part of the charges of Harmeling PT including but not limited to insurance companies, doctors, legal counsel, workers compensation carriers, or employers.

I HAVE READ AND UNDERSTOOD THE ABOVE

SIGNATURE: ________________________________DATE:___________________
PATIENT (or parent if patient is a minor)

(PLEASE PROCEED TO NEXT PAGE)

Health Questionnaire

Please **CIRCLE** if you have or had any of the following:

Osteoarthritis	Autoimmune disease	Seizures
Rheumatoid arthritis	High Cholesterol	Cancer
Blood Disorders	Heart problems	Stomach/GI problems
High Blood Pressure	Neuromuscular Disease	Stroke
Broken Bones	Circulation problems	Osteopenia
Breathing problems/Asthma	Infectious Disease	Osteoporosis
Thrombophlebitis (blood clots)	Balance problems	Diabetes
Endocrine disorder	Hearing/Vision impairment	Other____________

If circled above, please describe:

____

Please **CIRCLE** one:

Do you have a pacemaker/defibrillator?	YES	NO	
Are you or could you be pregnant?	YES	NO	
Are you currently breastfeeding?	YES	NO	
Are you taking Blood thinners?	YES	NO	
Are you allergic to latex?	YES	NO	
Do you have any implanted devices?	YES	NO	

If yes, please describe.

____

Have you had a cortisone injection?	YES	NO	DATE: __________
Are you taking NSAIDS?	YES	NO	DATE(of last dose): ______________

Please list all **ALLERGIES** that you have:

____

Please list all **MEDICATIONS and SUPPLEMENTS** you are currently taking:
A current list can be photocopied. Please provide to admin staff.

_____________________ _____________________ _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________

SURGERY: Please list all **surgeries** and dates you have had: **DATE**

____________________________________ ________________
____________________________________ ________________
____________________________________ ________________
____________________________________ ________________

What are your **GOALS** for physical therapy?

____

PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10 (highest)

Patient (or parent/guardian) Signature: ___________________________ Date: ________________

Patient Name:___________________________ **Date:**_____________

Pelvic Floor Questionnaire

Describe your main problem:

____

____

____

When did the problem begin? ____

Is it getting: Better Worse Staying the same (circle one)

Please list all abdominal surgeries and the year they occurred:

____

____

____

(If applicable)

Date of last pelvic exam? _________ **Date of last urologist exam?** __________

Incontinence: Urinary Fecal Both

Occurrence of incontinence or leakage

Never
Less than 1x/month
More than 1x/month
Less than 1x/week
More than 1x/week
Almost daily
Number of leaks per day________

Protection used

No protection used
Pantyshields
Mini pad
Maxi pad
Bladder control pad
Diaper

Severity

No leakage
Few drops
Wet underwear
Wet outerwear

Position or Activity with leakage

Laying down
Sitting
Standing
Changing positions (sit to stand)
Sexual activity
Strong urge
Laughing/sneezing

How long can you delay urination? can't delay minutes half hour hour indefinitely

What activities cause urine loss? vigorous activity moderate activity light activity no activity

How often do you urinate a day? 1-4x 5-8x 9-12x 13+

How often do you urinate at night? 0x 1x 2x 3x 4+

What is your approximate daily fluid intake in ounces? _________________

Do you have pain with urination? Yes No

Do you have trouble initiating a urine stream? Yes No

How frequent are your bowel movements? __________________

Are they mostly Formed Loose Hard Other:______________________________

Are your bowel movements painful? Yes No

Do you need to strain to have a bowel movement? Yes No

Do you use a fiber supplement if so what is it?____

Do you feel that this is a problem in your life? None Minor Moderate Major

Are you sexually active? Yes No

Is there pain when you are sexually active? Yes No

Do you have any feelings of pressure or "falling out"? Yes No

(If applicable)

Are you pregnant or attempting pregnancy? Yes No

Number of Children: ___________ **Type of delivery:**___________________________________

Complications? ____

History of past or present sexually transmitted diseases?

____

Are there any other concerns or comments you would like to mention?

____

____

You are more than welcome to bring a family member or friend to help you feel more comfortable.
Would you like a chaperone in the room? Yes No

Verbal explanation of the Physical Exam:
My role is to examine how your joints and muscles are working. To see how much control you have over contracting and relaxing them, and which ones are painful and/or weak.
I will examine you while standing, sitting and laying down to evaluate how your muscles and joints move and work.

I can get a lot of my information from an external exam. I do not have to do an internal exam if you do not want me to.

We can stop the exam if at any time you feel uncomfortable.

Patient Consent:
I, ________________________ give consent to have an **internal pelvic floor assessment**.

____ ____________________
Signature Date