Rue &
Primavera
Occupational, Physical & Hand Therapy

Patient Intake Packet Pelvic Floor Therapy

Date: _____Email Address: _____
Patient Name: _____SSN:_____
Occupation Title:_____Company Name:_____
Last First Middle
Date of Birth: ____/____/___Age:____ Gender: M_____F_____ Cell: (____)_____Home: (____)_____
Mailing Address: _____
Street City Zip
In case of an emergency, whom should we contact? _____
Phone: _(_____)_____ Relationship to patient: _____

Primary Insurance Information

Insurance Name: _____Phone: (_____)_____
Policy ID#:_____Group#:_____ Sponsors Name:_____
Sponsors DOB:_____ Sponsor SSN (Tricare patients only):_____

Secondary Insurance Information

Insurance Name: _____Phone: (_____)_____
Policy ID#:_____Group#:_____ Sponsors Name:_____
Sponsors DOB:_____ Sponsor SSN (Tricare patients only):_____

Work Related Incident

DOI: ____/____/_____Company Name:_____Company Phone:(_____)_____
Company Address: _____
Street City Zip

Auto/PIP Related Incident

Insurance Name:_____ID #:_____
Claim #:_____Is PIP available?:_____

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Informed Consent to treat for Physical/Occupational Therapy

Response to physical and occupational therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Rue and Primavera does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical and/or occupational therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

I, the undersigned patient or patient's representative, request admission to Rue and Primavera Rehabilitation for care and treatment. I certify that the information given is correct. I am aware that the practice of Rue and Primavera Rehabilitation is not an exact science and acknowledge that no guarantees or promises have been made as to the result of treatment of examination.

Signature_____Date_____

Joint Notice of Privacy Practices Acknowledgment

We keep a record of the health care services we provided you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name Relationship to patient (parent, legal/personal representative)

Release of Medical Information

Please include the names of persons with whom we are allowed to discuss your medical and billing information (please include other medical facilities that you may need us to send information to other than your referring provider):

_____ _____

Name Relationship

_____ _____

Name Relationship

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No Show and Cancellation Policy

Thank you for choosing Rue and Primavera for your injury needs. We are happy to be of service to you. Rue and Primavera reserves treatment time exclusively for your benefit. In order for us to help you with your condition it is important that you keep your scheduled appointments. It is not our intention to cause undue financial hardship for you as the patient, however we cannot absorb a loss in revenue due to lack of compliancy.

- Late Cancelations: Appointments must be cancelled **24 hours PRIOR** to your scheduled appointment or there will be a **$80.00** fee not covered by your insurance company. If we are able to reschedule you in the same week (keeping the same number of scheduled appointments) we will waive this fee. **We must hear from you during business hours 9-5pm** to cancel. If you leave a voicemail after hours the fee will be billed to you, as we do not have the chance to fill your cancelled appointment.

- No Shows: If you do not show up for your scheduled appointment and do not call to notify us of your absence, you will be charged a fee of **$125.00**. This fee will not be waived under any circumstances.

All fees are due at the time of the next scheduled appointment.

***PATIENTS WHO CANCEL 3 TIMES OR NO-SHOW 2 TIMES WILL BE DISHCARGED.**

RELEASE OF MEDICAL INFORMATION/ FINANCIAL AGREEMENT/ ASSIGNMENT OF BENEFITS/ MEDICARE CERTIFICATION/ PERSONAL VALUABLES: I authorize Rue and Primavera Rehabilitation to release any information necessary to facilitate the processing of health care claims, and audit of payments relative to this care. I consent to the release of any information as needed to my referring and primary physician and to other health facilities or agencies as I direct or as required by law.

Please read and print name below:

I,_____ understand Rue and Primavera's no show and cancelation policy. I am responsible to know when I scheduled my appointments and be there on those times and days.

Signature:_____Date:_____

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Past Medical History

Name:_____Age:_____Todays Date:_____

1.) Please describe the problem that brought you here:

_____

_____

2.) When did you problem first begin? _____Months ago or _____ years ago.

3.) Was your first episode of the problem related to a specific incident? YES/NO

4.) Since then is it: _____ Staying the same, _____ Getting worse, _____ Getting better

Why or how?_____

5.) If pain in present, rate the pain on a 0-10 scale; 10 being the worst_____

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

_____

6.) Describe previous treatment/exercises: _____

_____

7.) Activities/events that cause or aggravate your symptoms/ Check/Circle that apply:

____Sitting greater than _____ Minutes
____Walking greater than _____Minutes
____Standing greater than _____Minutes
____Changing positions (i.e. Sit to Stand)
____Light activity (light housework)
____Vigorous activity/exercise (Run/weightlift/jump)
____Sexual activity
____Other, please list: _____

____With cough/sneeze/straining
____With laughing/yelling
____With lifting/bending
____With cold weather
____With triggers-running water/keys in door
____With nervousness/anxiety
____No activity affects the problem

8.) What relieves your symptoms? _____

9.) How has your lifestyle/quality of life been altered/changed because of the problem?

Social Activities (Exclude physical Activities), specify: _____
Diet/Fluid Intake, specify: _____
Physical Activity, specify:_____
Work, specify: _____
Other: _____

10.) Rate the severity of this problem from 0-10 with 0 being no problem and 10 being the worst: _____

11.) What are your treatment concerns and goals? _____

_____

12.) Since the onset of your current symptoms have you had?

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder functions
Y/N Malaise (unexplained tiredness)
Y/N Unexplained muscle weakness
Y/N Night pain/Sweats
Y/N Numbness/ Tingling
Y/N Other/Describe: _____

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Health History

Date of last Physical Exam: _____ Tests: Preformed: _____

General Health (please circle): Excellent Good Average Fair Poor

Occupation:_____

Hours/Week_____ On Disability or leave? _____ Activity Restrictions? _____

Mental Health: _____

Current level of stress: ____High ____Med ____Low

Psych Therapy? Y/N

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

Describe: _____

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

Cancer	Stroke	Emphysema/ Chronic bronchitis
Heart Problems	Epilepsy/seizures	Asthma
High Blood pressure	Multiple sclerosis	Allergies: Latex Sensitivity/Other:_____
Ankle Swelling	Head Injury	
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	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/Bulimia	Joint Replacement	Sexually Transmitted Disease
Smoking History	Bone Fracture	Physical or Sexual Abuse
Vision/Eye Problems	TMJ/ Neck Pain	Pelvic Pain

Other/Describe: _____

Surgical/ Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/Prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/Joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other Describe: _____

Ob/Gyn History (females only)

Y/N	Childbirth Vaginal Deliveries #_____	Y/N	Vaginal Dryness
Y/N	Episiotomy #_____	Y/N	Painful Periods
Y/N	C-Section #_____	Y/N	Menopause-when? _____
Y/N	Difficult Childbirth #_____	Y/N	Painful Vaginal Penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic Pain
Y/N	Other/Describe: _____		

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Males Only

Y/N	Prostate Disorders	Y/N	Erectile dysfunction
Y/N	Shy Bladder	Y/N	Painful Ejaculation
Y/N	Pelvic Pain		
Y/N	Other/Describe: _____		

Medications: (Including Vitamins)

Pills, Injections, patch	Start Date	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pelvic Symptom Questionnaire

Bladder/ Bowel Habits/ Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in Urine
Y/N	Urinary Intermittent/Slow Stream	Y/N	Painful Urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling Bowel/urge/fullness
Y/N	Staining or pushing to empty Bladder	Y/N	Constipation/Straining
Y/N	Dribbling after Urination	Y/N	Trouble holding back gas/feces
Y/N	Constant Urine Leakage	Y/N	Recurrent Bladder Infections
Y/N	Other/Describe: _____		

1.) Frequency or urination: Awake hours: ____ Per day Sleep hours_____ times per night
2.) When you have normal urge to urinate, how long can you delay before you have to go to the toilet?
_____Minutes, _____Hours, _____Not at all
3.) The usual amount of urine passed is: _____Small _____Medium _____Large
4.) Frequency for bowel movements: _____time per day, _____times per week, or _____.
5.) 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.
6.) If constipation is present describe management techniques: _____
_____
_____
7.) Average fluid intake (One glass is 8 oz. or one cup)_____per day. Of this total how many glasses are caffeinated? _____per day.
8.) Rate a feeling or organ "falling out"/prolapse or pelvic heaviness/pressure"
____None present
____Times per month (specify if related to activity or your period)
____With standing for _____ minutes or _____ hours.
____With exertion or straining
____Other

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SKIP QUESTIONS IF NO LEAKAGE/INCONTINENCE

9.) Bladder leakage- Number of episodes

____No leakage
____Times per day
____Times per week
____Times per month
____Only with physical exertion/cough

10.) Bowel leakage- Number of episodes

____No leakage
____Times per day
____Times per week
____Times per month
____Only with physical exertion/strong urge

11.) On average, how much urine do you leak?

____No leakage
____Just a few drops
____Wets underwear
____Wets outerwear
____Wets the floor

12.) How much stool do you lose?

____No leakage
____Stool Straining
____Small amount in underwear
____Complete emptying

13.) What form of protection do you wear? (Please complete only one)

____None
____Minimal Protection (Tissue paper/paper towel/pantishields)
____Moderate Protections (Absorbent Product, maxi pad)
____Maximum Protections (Specialty Product/Diaper)
____Other: _____

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

1. Have you fallen two or more time in the past 12 months? YES or NO
2. Are you here today because of a fall? YES or NO
3. Do you have any problems with walking or balance? YES or NO

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Informed Consent for Pelvic Floor Evaluation and Treatment

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and 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 evaluation, treatment and options available for my condition.

I also 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 my 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 and use of speculum.

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, photo biomodulation, heat, cold, stretching and strengthening exercises, soft tissue and/or join mobilization and education instruction.

Potential risks: 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 id does not subside in 1-3 days, I agree to contact my therapist.

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.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from 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.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her options regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated.

A chaperone can be provided and maybe requested by the therapist and/or patient.

_____I would like a chaperone present during the intimate part of the exam

_____I decline a chaperone

Patient Signature:_____ Date:_____

Signature of Parents or Guardian (If applicable):_____

Therapist Signature:_____

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