



*Cindi A. Prentiss, P.T., P.C.*

**Physical Therapy & Beyond**

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**PATIENT INFORMATION FORM**

PLEASE PRINT LEGIBLY

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: (Circle One) Married/Single/Divorced/Widow/Widowed Spouse/Partner's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F Height: \_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_ R/L Hand Dominant: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

City / State / Zip: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_ Best way to contact you? \_\_\_\_\_

Employer Name / Work Address: \_\_\_\_\_

Current Work Status: Full Time Part Time Retired Unemployed On Disability Restricted Work

Student Homemaker Not Working Due to Injury Occupation: \_\_\_\_\_

Is this condition due to: \_\_\_Auto Accident \_\_\_Workers Comp Injury \_\_\_Slip & Fall \_\_\_Other

If you currently have an attorney working with you, please provide his/her name and address:

Atty Name: \_\_\_\_\_ Address: \_\_\_\_\_

Have you received **physical therapy**, **occupational therapy**, and/or **speech therapy** since January 1<sup>st</sup> of this calendar year? Yes / No If yes, which therapy did you have and what were you being treated for?

Are you now having homecare services of any kind? Yes / No

**Whom may we thank for referring you?** \_\_\_\_\_

Please Mark \* **C** for **Current** Conditions or \* **P** for **Past** Conditions

___Fibromyalgia	___Neck Pain	___Knee/Lower Leg Pain	___Heart Disease	___High Blood Pressure	___Hepatitis
___Rheumatoid Arthritis	___Back Pain	___Ankle/Foot Pain	___Angina	___Stroke	___Cancer
___Osteoarthritis	___Sciatica	___Jaw Pain	___Pacemaker	___Lupus	___Tumor
___Osteopenia	___Abnormal Posture	___Hearing Loss	___Diabetes	Difficulty ___Walking	___HIV/Aids
___Osteoporosis	___Headaches	___Kidney Disorder/Stones	___Neuropathies	___Parkinson's Disease	___Asthma
___Broken Bones	___Shoulder Pain	___Prostate Problems	___Peripheral Vascular Disease	___Multiple Sclerosis	___COPD
Joint ___Swelling/Stiffness	___Elbow/Upper Arm pain	___Painful Urination	___General Fatigue	___Muscular Dystrophies	___Cigarette Smoker
___Pregnancy	___Wrist/hand	___Bladder	___Lack of	___Epilepsy	___Drugs/Alcohol

	pain	Infection	Coordination		Dependence
___ Dermatitis/Eczema /Rash	___ Hip/Upper leg Pain	___ Pelvic Pain	___ Vertigo	___ Liver/Gall Bladder Disorder	___ Depression
		___ Loss of Bladder Control			___ Other

Rev.11/11

Please state the body parts where your problems or injuries are located, and give a brief description of your current problems including difficulties with any functional activities: \_\_\_\_\_

\_\_\_\_\_

Please give a **date** (actual or approximate) this problem started: \_\_\_\_\_

Please describe **how** your condition or injury started: \_\_\_\_\_

\_\_\_\_\_

Have you ever been treated for this condition before? Yes / No

Date and location where you were last treated: \_\_\_\_\_

Are you currently being seen by a chiropractor for the same condition? Yes / No

**Please check any of the following characteristics that you are feeling:**

\_\_\_ Sharp Pain \_\_\_ Dull Ache \_\_\_ Throbbing \_\_\_ Numbness \_\_\_ Burning \_\_\_ Pins/Needles  
\_\_\_ Constant \_\_\_ Usually present \_\_\_ Sometimes present \_\_\_ Occurs once in a while

**Please circle the number that represents the intensity of your pain when you are at rest:**

(No Pain) (Minimal Pain) (Moderate Pain) (Unbearable Pain)  
0 1 2 3 4 5 6 7 8 9 10

**Please circle the number that represents the intensity of your pain during any movements:**

(No Pain) (Minimal Pain) (Moderate Pain) (Unbearable Pain)  
0 1 2 3 4 5 6 7 8 9 10

Please check all the problems that you currently have:

\_\_\_ Pain \_\_\_ Shooting Pain \_\_\_ Inability to Work \_\_\_ Difficulty Walking  
\_\_\_ Weakness \_\_\_ Loss of Motion \_\_\_ Muscle Tightness \_\_\_ Loss of Balance  
\_\_\_ Stiffness \_\_\_ Loss of Function \_\_\_ Extreme Fatigue \_\_\_ Unable to Walk Stairs  
\_\_\_ Headaches \_\_\_ Unable to Sleep

Please state anything that makes your problem **better**: \_\_\_\_\_

\_\_\_\_\_

Please state anything that makes your problem **worse**: \_\_\_\_\_

\_\_\_\_\_

When is your next appointment with the doctor who is seeing you for this condition? \_\_\_\_\_

What are your **goals** you would like therapy to help you with? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Consent Form**

Thank you for choosing Cindi A. Prentiss, P.T., and P.C. for your physical therapy services. In order to provide a thorough physical therapy evaluation your physical therapist may perform an internal pelvic floor muscle examination, external pelvic musculature examination and may also examine the urogenital region. You and your physical therapists have discussed why this evaluation is needed and how it will be performed.

Your physical therapist is a female. No chaperone will be provided during your physical therapy evaluation and treatment sessions unless you request a chaperone be present. You may choose to bring a friend or family member during the physical therapy evaluation or treatment at any time.

By signing below, you consent to the examinations listed above and agree that your questions have been answered.

Patient's Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**Consent for Pelvic Floor Examination and Biofeedback**

**Please read the following and confirm that to your knowledge, you do not have any of these medical conditions.**

1. Pregnancy, potential pregnancy or recent post-partum.
2. Recent vaginal or rectal surgery.
3. Fusion, unfixated fracture, recently sutured nerves or tendons.
4. Cardiac pacemaker, history or cardiac arrhythmia.
5. Metal implants.
6. Recent vaginal (non-menstrual) or rectal bleeding.
7. Malignancy in the area to be treated.
8. Known skin irritations due to the use of gel or tape.
9. Recent history of urinary retention or post void residual volume greater than 200cc
10. Diminished sensory perception.
11. Severe Atrophic vaginitis.
12. Active urinary tract infection or infectious lesions.

Please check your response below:

**I confirm to the best of my knowledge that I do not have any of the above listed medical conditions.**

**I do have at least one of the above listed medical conditions, which I have circled, and I will further discuss with my therapist.**

*I consent to the Pelvic Floor Examination and Biofeedback*

Patient's Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**Cindi A. Prentiss P.T., P.C.**  
**WOMEN'S HEALTH SURVEY**

**Surgical History: (check all that apply & state year)**

- |   |   |
|---|---|
| <input type="checkbox"/> back/neck surgery    | <input type="checkbox"/> kidney surgery   |
| <input type="checkbox"/> bladder repair       | <input type="checkbox"/> hysterectomy ( <input type="checkbox"/> abdominal<br><input type="checkbox"/> vaginal) |
| <input type="checkbox"/> gall bladder surgery | <input type="checkbox"/> appendectomy   |
| <input type="checkbox"/> hernias              | <input type="checkbox"/> ovaries removed  |
| <input type="checkbox"/> other                |   |
| Do you have scars from surgery? _____         | Where are the scars? _____  |

**Gynecological History: (check all that apply)**

- #of pregnancies\_\_ # of vaginal deliveries\_\_ # of C-Sections\_\_ Length of pushing\_\_  
 # of episiotomies\_\_
- Do you have a painful episiotomy scar? Yes No
- Do you have a history of urinary track infections? Yes No
- When was your **Menopause** onset? Month\_\_\_\_\_ Year\_\_\_\_\_
- Do you have a history or urine loss as a child? Yes No
- As an adolescent? Yes No
- After child birth? Yes No

**Current Medications**

<b>Prescription</b>	<b>Non-Prescription</b>

**Allergies:** \_\_\_\_\_

Have you been on Hormone Replacement therapy? Yes No

**Dosage:** \_\_\_\_\_ **Type:** \_\_\_\_\_

Estrogen \_\_\_\_\_  
 Progesterone \_\_\_\_\_

Pills \_\_\_\_\_  
 Patch \_\_\_\_\_  
 Cream \_\_\_\_\_

**Daily fluid intake:**

# of cups per day \_\_\_\_\_. What do you drink? \_\_\_\_\_ Of those how many are caffeinated? \_\_\_\_\_  
 Do you restrict fluids because of your incontinence? Yes No

**Previous Treatment for Incontinence**

Have you done exercise to control urine loss?	Yes	No
Has your doctor prescribed any medication to treat urine loss?	Yes	No
Have you had any surgical procedures to treat urine loss?	Yes	No

**Do you experience any of the following?**

Loss of urine with coughing, laughing, sneezing?	Yes	No
Loss of urine when lifting objects?	Yes	No
Loss of urine with exercise, running, etc?	Yes	No
Loss of urine when you have strong urge to urinate?	Yes	No
Loss of urine on the way to the bathroom?	Yes	No
Loss of urine with "key in lock"? (can't make it to bathroom)	Yes	No
Loss of urine just as getting to toilet/remove clothes?	Yes	No

**Do you:**

Experience and urge to urinate when you hear running water and then you are unable to get to the toilet?	Yes	No
Have difficulty initiating a urine stream?	Yes	No
Have pain with urination?	Yes	No
Have burning with urination?	Yes	No
Have blood in urine?	Yes	No
Have to strain to empty your bladder?	Yes	No
Dribble urine when you urinate?	Yes	No
Dribble after you empty your bladder?	Yes	No

**When you have an uncontrolled loss of urine:**

Is it usually a little amount?	N/A	Yes	No
Is it usually a large amount?	N/A	Yes	No

**Voiding Patterns:**

Voiding frequency:	# of times per day	# or times per night
Incontinence:	# of episodes per day	# of episodes per night
Amount of urine lost:	Large small	few drops

**Protective Devices:**

**What type of protective devices do you use? (Check all that apply)**

Pantyliner	incontinence pad	( Poise Depends Serenity)
Sanitary pad (mini)		incontinence brief
Sanitary pad (maxi)		other

# of pads used each day? _____	
Do you soak the pad fully?	Yes No
Do you change the pad each time it is wet?	Yes No

*Cindi A. Prentiss P.T., P.C.*

**Bowel Habits:**

*How often do you have a bowel movement?*

*Are you ever constipated*

Yes No

*How do you resolve this?*

*Do you strain?*

Yes No

*Do you experience diarrhea?*

Yes No

*Do you use laxatives ?*

Yes No

*How often per week?*

*Do you use enemas?*

Yes No

*How often per week?*

*Do you include fiber in your diet? (Fruit, vegetables, bran, etc.)* Yes No

**Mobility/Self-Care**

**Do you:**

*Use a cane*

Yes No

*Use a walker*

Yes No

*Lean on furniture for balance?*

Yes No

**Do you have difficulty?**

*with getting on/off the toilet?*

Yes No

*getting clothes on/off?*

Yes No

*with toilet hygiene?*

Yes No

**Psychosocial Status:**

**Living arrangements:**

*Do you live alone?*

Yes No

*Occupation:* \_\_\_\_\_

*Do you do any recreational activities? Yes No What kind:* \_\_\_\_\_

*Have you had to restrict your activities due to urinary incontinence?*

Yes No

*Have you had to restrict your activities due to pelvic pain?*

Yes No

*What are your feelings about your urinary incontinence/pelvic pain on a scale of 1-10?*

0 1 2 3 4 5 6 7 8 9 10

*no impairment*

*severe impairment*

*Have you had changes in intimate relationships/sexual functioning due to*

urinary incontinence? Yes No

Have you had changes in intimate relationships/sexual functioning due to pelvic pain? Yes No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Cindi A. Prentiss P.T., P.C.

PATIENT INSURANCE AND AUTHORIZATION FORM

Patient Name (print): \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Primary Insured: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_ SS #: \_\_\_\_-\_\_\_\_-\_\_\_\_

Male/ Female Relationship to Patient: SELF SPOUSE CHILD OTHER

Adj / Caseworker: \_\_\_\_\_ Adj. Phone #: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Named Insured: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_ SS #: \_\_\_\_-\_\_\_\_-\_\_\_\_

Male/ Female Relationship to Patient: SELF SPOUSE CHILD OTHER

Tertiary Insurance Carrier: \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Named Insured: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_ SS #: \_\_\_\_-\_\_\_\_-\_\_\_\_

Male/ Female Relationship to Patient: SELF SPOUSE CHILD

INSURANCE AUTHORIZATION SECTION

Physical Therapy & Beyond strongly believes that patients should not pay for any services their insurance companies are obligated to cover. As a courtesy to our patients, we will bill your insurance company in an attempt to recover any payments due fully for the services provided. Any uncollected fees are billed to the patient only after all options to get paid for services have been exhausted by our Accounting Department.

I understand that I am fully responsible for notifying Physical Therapy & Beyond of any changes regarding my medical coverage during ongoing treatment. The changes in medical coverage may include an auto accident, a work-related injury, termination of insurance, a change of insurance company and/or policies. If I do NOT comply with this policy, I understand and am fully aware I will be liable for any and all outstanding bills.

I further understand that I am responsible for paying the balance of charges in the event my insurance does not fully cover for all services provided, including deductible, co-pay, co-insurance or percentage authorized or limited by law.

Additionally, I hereby authorize and assign insurance benefits to Physical Therapy & Beyond and the release of any and all medical records as requested by any insurance company so that my bills can be processed and paid.

\_\_\_\_\_  
Patient Signature (Parent Signature if under 18) \_\_\_\_\_ Date \_\_\_\_\_

**Acknowledgement of Notice of Privacy Practices**

I, \_\_\_\_\_, have been offered a copy of the Notice of Privacy Practices from Physical Therapy& Beyond. **Patient Signature** \_\_\_\_\_ Date \_\_\_\_\_

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Physical Therapy& Beyond, state that \_\_\_\_\_ has been offered our current Notice of Privacy Practices.

Cindi A. Prentiss, P.T., P.C.,

**Patient Release Form**

1. I authorize Cindi A. Prentiss, P.T., P.C., and /or staff to release information to the following physician (s):

Carbon Copy PT Reports to:

List the Physician writing your prescription so that we may send all your medical reports.

**physicians name** \_\_\_\_\_  
 address \_\_\_\_\_  
 city, state, zip \_\_\_\_\_  
 phone number \_\_\_\_\_  
 type of doctor \_\_\_\_\_

List other Physicians you would like us to send a copy of your physical therapy reports to.

<b>physicians name</b> _____	<b>physicians name</b> _____
address _____	address _____
city, state, zip _____	city, state, zip _____
phone number _____	phone number _____
type of doctor _____	type of doctor _____

**Patient Signature**

**Date**

2. I authorize Cindi A.Prentiss, P.T., P.C., and /or staff to discuss my healthcare with the following person(s)

List the people in your personal life you are allowing us to share your info. with.

**name** \_\_\_\_\_  
 address \_\_\_\_\_  
 city, state, zip \_\_\_\_\_  
 phone number \_\_\_\_\_  
 relationship to you \_\_\_\_\_

**name** \_\_\_\_\_  
 address \_\_\_\_\_  
 city, state, zip \_\_\_\_\_  
 phone number \_\_\_\_\_  
 relationship to you \_\_\_\_\_

**Patient Signature**

**Date**

3. I hereby authorize Cindi A.Prentiss, P.T., P.C. and/or staff to evaluate and treat my Son/ Daughter

\_\_\_\_\_ for Physical Therapy.  
 Print Minor's Name



_____	_____
<b>Parent Signature</b>	<b>Date</b>
_____	_____
<b>Witness Signature</b>	<b>Date</b>

**To Our Patient Regarding Cancellations and No-Shows**

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and or/your Physical Therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your Physical Therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hour notice in the event of a cancellation. When you call in, it is your responsibility to have an alternative date and time in mind. This will ensure that you get the full prescribed number of treatments for that week whenever possible.
- There is a charge of \$25 for a cancellation without proper notice. This charge will not be covered by insurance and must be paid by you personally.
- Worker's Compensation and Personal Injury patients are hereby informed that documentation of any missed appointments is forwarded to the Case Manager and Primary Physician and could jeopardize your claim.
- When rescheduling a missed appointment, you may need to see a therapist who you have not seen before. Be assured that all of our therapists are experienced professionals, who will study your patient chart, so you will be in good hands. You will return to your usual therapist in the next regularly scheduled visit.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. The following may seem to be a reason not to come for your treatment. A) You're feeling worse and think the treatment is not working or B) You're feeling better and it's a great day for wind surfing. Neither of these conditions is legitimate as a reason not to come in. A) If you are in pain, come in and get it fixed, B) If you are out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself.

**To Our Patient Regarding Cancellations and No-Shows**

When you don't show for a scheduled appointment, **three** people are hurt.

- 1. You**, because you don't get the treatment you need as prescribed by the doctor and or the Physical Therapists.
- 2. Your Physical Therapist**, who now has an open space in their schedule that was reserved for you personally.
- 3. A Patient who is in pain** who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard by signing the agreement below. We're looking forward to working with you.



\_\_\_\_\_ Date: \_\_\_\_\_  
*Patient Signature (Parent/ Guardian for Minor)*

\_\_\_\_\_ Date: \_\_\_\_\_  
*Interviewer Signature*