OrthoRehab PHYSICAL THERAPY

THERAPIST OWNED & OPERATED

PATIENT INFORMATION

Patient's Legal Name _____ Social Security # _____ Sex Ⓜ Ⓕ

Birth Date _____ Age _____ Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced ○ Separated

Mailing Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Do we have permission to leave a message on your phone? ○ Yes ○ No

Text or email appointment reminders/communication? ○ Yes ○ No Email: _____

Have you received home health services in the last 60 days? ○ Yes ○ No

List other providers you are treating with (excluding your MD): _____

SPOUSE, PARENT/LEGAL GUARDIAN & EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Birth Date _____ Sex Ⓜ Ⓕ

Work # _____ Cell # _____

Place of Employment _____ Occupation _____

In case of emergency, please contact: _____ Relationship _____

Home # _____ Work # _____ Cell # _____

ACCIDENT INSURANCE INFORMATION – present ID to front desk personnel

PLEASE COMPLETE: **Work Related** ○ Yes ○ No **Auto Accident** ○ Yes ○ No **Other Accident** ○ Yes ○ No

Accident Insurance _____ Claim # _____

Adjuster's Name & Phone Number _____

Date of Accident _____ Describe _____

HEALTH INSURANCE INFORMATION - present ID & insurance card(s) to front desk personnel

Primary Insurance _____ Secondary Insurance _____

Subscriber's Name _____ Subscriber's Name _____

Subscriber's Date of Birth _____ Subscriber's Date of Birth _____

ADDITIONAL INFORMATION

Place of Employment _____ Occupation _____

Family Physician _____ Referring Physician _____

I understand that should I default on payment of this account and collection agency services are required, all costs of collection including attorney fees will be added to the balance of the account.

Signature _____ Date _____

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I understand that:

- As part of my health care, Orthopedic Rehab Inc. originates and maintains health records describing my health records describing my health history, symptoms, examinations, diagnoses, and treatment.
- The use and disclosure of my protected health information (PHI) by Orthopedic Rehab Inc. is necessary to provide my medical care, obtain payment for my treatment, and carry out the practice's health care operations.
- Orthopedic Rehab Inc. uses PHI to communicate with you via your phone an email for purposes as appointment reminders and review requests. This information is private and used for communicating content to you, the patient. PHI is never shared or sold for any other reason.
- I have the option to receive a copy of **Orthopedic Rehab Inc. Notice of Privacy Practices** which provides a more complete description of the use and disclosure of my health information, and that I have the right to review that Notice prior to signing this consent. I also understand that Orthopedic Rehab Inc. reserves the right to change the Notice and its privacy practices at any time and that if I request, Orthopedic Rehab Inc. will mail me a copy of any revised Notice prior to its implementation.

I give Orthopedic Rehab Inc. permission to talk to the following people regarding my account and health information:

NAME:

RELATIONSHIP TO PATIENT:

CANCELLATION AND NO-SHOW POLICY

Your appointments are reserved especially for you and are very important to our team. We understand that sometimes schedule changes are necessary and therefore, we respectfully request at least 24-hour notice for cancellations or rescheduling of appointments. Because of the busy nature of our clinic, 24-hour notice allows us time to offer your appointment to another patient. Missed scheduled appointment, without providing 24-hour advanced notice, will be charged a $25 fee.

ASSIGNMENT OF BENEFITS AND INSURANCE DISCLAIMER

I authorize my health insurance to make payment of medical benefits directly to Orthopedic Rehab Inc. I understand that I am liable for any charges incurred should my insurance or the liable party's insurance deny payment for ANY reason.

Although Orthopedic Rehab Inc. contracts with most insurance providers, they bill my insurance as a courtesy to me. I will provide all pertinent and related insurance information, including any accident, automobile, liability, and or health insurance. Orthopedic Rehab Inc. reserves the right to lien patient recoveries from legal or insurance settlements for unpaid charge when permitted by law. Orthopedic Rehab Inc. will not bill attorneys for claims.

I am responsible for knowing what my medical and outpatient physical therapy benefits are. **I agree to pay any co-payments, co-insurance, and deductibles at the time of service.**

Orthopedic Rehab Inc. will arrange a payment plan and/or assist me with Care Credit, when necessary. Unless payment arrangements are made with Orthopedic Rehab Inc., past due balances will be sent to an outside collection agency. I understand that should I default on payment of my account and collection agency services are required, all costs of collection including legal fees will be added to the balance of my account.

PATIENT OR GUARANTOR SIGNATURE _____ DATE _____

Medical History

OrthoRehab PHYSICAL THERAPY

NAME: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

WHAT EASES YOUR PAIN? _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT ARE YOUR GOALS IN PHYSICAL THERAPY?

_____

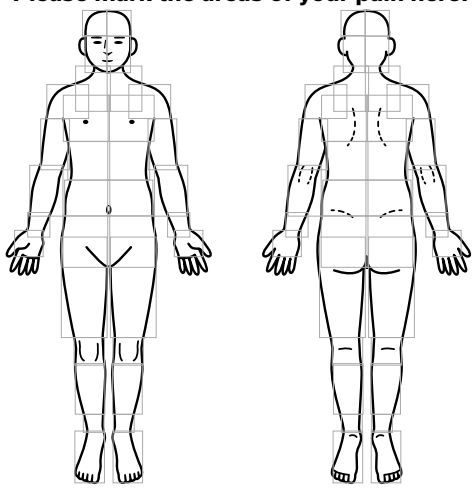
HAVE YOU HAD PREVIOUS TREATMENT FOR THIS PROBLEM?

PLEASE SPECIFY: PT ☐ CHIROPRACTIC ☐ OTHER _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS?

X-RAY ☐ CT SCAN ☐ MRI ☐ EMG ☐

Please mark the areas of your pain here:



Please mark any of the following past and current conditions that apply to you *(be as thorough as possible)*:

CONDITION	YES	NO
Allergies		
Anemia		
Anxiety		
Arthritis		
Asthma		
Autoimmune Disorder		
Cancer		
Cardiac Conditions		
Cardiac Pacemaker		
Chemical Dependency		
Circulation Problems		
Currently Pregnant		
Depression		
Diabetes		

CONDITION	YES	NO
Dizzy Spells		
Emphysema/Bronchitis		
Fibromyalgia		
Fractures		
Gallbladder Problems		
Headaches		
Hearing Impairment		
Hepatitis		
High Cholesterol		
High/Low Blood Pressure		
HIV/AIDS		
Incontinence		
Kidney Problems		
Metal Implants		

CONDITION	YES	NO
MRSA		
Multiple Sclerosis		
Muscular Disease		
Osteoporosis		
Parkinsons		
Rheumatoid Arthritis		
Seizures		
Smoking		
Speech Problems		
Strokes		
Thyroid Disease		
Tuberculosis		
Vision Problems		

Please explain any of the above marked "Yes" and describe any additional conditions or precautions:

Injury a result of a fall in the past year? YES ◯ NO ◯

Have you had two or more falls in the last year? YES ◯ NO ◯

Please describe **all surgeries** or hospitalizations *(continue on back side if necessary)*:

SURGERY TYPE: **DATE** *(mm/yyyy)*:

Please list **all medications** you are currently taking *(continue on back side if necessary)*:

MEDICATION	DOSAGE	FREQUENCY	ROUTE	REASON TAKING

SIGNATURE: _____ **DATE:** _____

OrthoRehab PHYSICAL THERAPY

PELVIC FLOOR INFORMED CONSENT FOR PHYSICAL THERAPY EVALUATION AND TREATMENT

The term "informed consent" means the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to me. The therapist provides a variety 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 acknowledge and understand 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 for my therapist to 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. Prior to the examination, the therapist should evaluate for the presence of contraindications and/or precautions to internal palpation. During the examination, I agree to actively participate by answering questions and providing feedback to the therapist. If, at any time during the examination, I wish to discontinue the examination I will verbally tell the evaluating therapist. The therapist will discontinue the examination if I make this request.

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, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I acknowledge that I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. I understand that this discomfort is usually temporary, but that if it does not subside in 1-3 days, I agree to contact my therapist. The risk of this examination is relatively equal to that of a gynecological exam. Potential benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I understand that I may experience increased strength, awareness, flexibility and endurance in my movements. I understand that I may experience decreased pain and discomfort. I understand that 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 for therapy to be effective, I must come on days and times as scheduled unless urgent circumstances 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.

The undersigned attests that he/she is the patient or the patient's guardian, legal representative, or parent, and that he/she has read and understand the information above, and that he/she has had the opportunity to have all of his/her questions about the pelvic floor therapy answered to his/her satisfaction, and hereby agrees to participate in the therapy program.

_____
Name of Patient (print)

_____ _____
Signature of Patient Date

_____
Name of Parent/Guardian & Relationship (print)

_____ _____
Signature of Parent/Guardian Date

OrthoRehab PHYSICAL THERAPY

DRY NEEDLING CONSENT & INFORMATION FORM

What is Dry Needling?

Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments, or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental Medicine; that is, it does not have the purpose of altering the flow of energy ("Qi") along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low-back pain.

Is Dry Needling safe?

Drowsiness, tiredness or dizziness occurs after treatments in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-25% of treatments and is considered normal. Temporary pain during dry needling occurs in 60-70& of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, this is not necessarily a "bad" sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the head or neck regions. Dry needling is very safe; however, serious side effects can occur in less than 1 per 10,000 (less than 0.01%) treatments. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, dry cough, bluish discoloration of the skin, or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling; however, this is a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000).

Is there anything your practitioner needs to know?

1. Have you ever fainted or experienced a seizure? **Please Select One**
2. Do you have a pacemaker or any other electrical implant? **Please Select One**
3. Are you currently taking anticoagulants (blood-thinners e.g. aspirin, warafin, coumadin)? **Please Select One**
4. Are you currently taking antibiotics for an infection? **Please Select One**
5. Do you have a damaged heart valve, metal prosthesis or other risk of infection? **Please Select One**
6. Are you pregnant or actively trying for pregnancy? **Please Select One**
7. Do you suffer from metal allergies? **Please Select One**
8. Are you a diabetic or do you suffer from impaired wound healing? **Please Select One**
9. Do you have Hepatitis B, Hepatitis C, HIV, or any other infectious disease? **Please Select One**
10. Have you eaten in the last two hours? **Please Select One**

Single-use, disposable needles are used in this clinic.

STATEMENT OF CONSENT

I confirm that I have read and understand the above information, and I consent to having dry needling treatments. I understand that I can refuse treatments at any time.

Signature: _____

Printed name: _____ Date: _____

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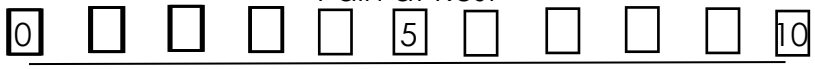
Name: _____

Date: _____

Pain Scales

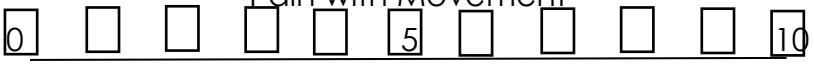
Please make a slash on the following lines to indicate your level of pain.

Pain at Rest



No Pain Worst Pain Imaginable

Pain with Movement

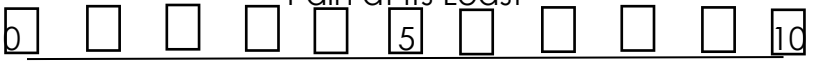


No Pain Worst Pain Imaginable

Pain at its Worst

No Pain Worst Pain Imaginable

Pain at its Least



No Pain Worst Pain Imaginable

PELVIC FLOOR THERAPY QUESTIONNAIRE

Name _____ Date _____

History

Number of:
Pregnancies_____ Vaginal deliveries _____ Cesarean deliveries _____ Episiotomies _____

Date of Last:
Pap smear _____ Menstrual cycle_____ Birth weight of largest baby _____

Did you have any trouble healing after delivery Y☐ N☐
Do you have a history of sexual abuse or trauma Y☐ N☐
Are you having regular periods Y☐ N☐

Do you have frequent urinary tract infections Y☐ N☐

Pain

Do you have pain with:
- Sexual intercourse Y☐ N☐
- Pelvic Exam Y☐ N☐
- Tampon use Y☐ N☐
- Back, leg, groin or abdominal Y☐ N☐

Bladder Symptoms

Do you lose urine when you:
- Cough/sneeze/laugh Y☐N☐
- On the way to the bathroom Y☐N☐
- Hear running water Y☐N☐
- Lift/exercise/dance/jump Y☐N☐
- Have a strong urge to urinate Y☐N☐
- Other _____ Y☐N☐

Do you wet the bed Y☐N☐
Have burning/pain w/urination Y☐N☐
Strain to empty your bladder Y☐N☐
Have a falling out feeling Y☐N☐
Have an urgency of urination Y☐N☐
Difficulty starting a stream of urine Y☐N☐
Feel unable to empty bladder fully Y☐N☐
Have pain w/a full bladder Y☐N☐
Urinate more than 7 times daily Y☐N☐

Bowel Symptoms

Strain to have a bowel movement Y☐N☐
Include fiber in your diet Y☐N☐
Take laxatives/enema regularly Y☐N☐
Have a very strong urge to move your bowels Y☐N☐
Leak/strain feces Y☐ N☐
Have diarrhea often Y☐ N☐
Leak gas by accident Y☐ N☐
Have pain w/bowel movement Y☐ N☐

How often do you move your bowels per day/week _____/_____
Most common stool consistency:
liquid ☐ soft ☐ firm ☐ pellets ☐ other _____

Incontinence Impact Questionnaire – Short Form IIQ-7

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life which may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your:

	Not At All	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐	☐	☐	☐
2. Physical recreation such as walking, swimming, or other exercise?	☐	☐	☐	☐
3. Entertainment activities (movies, concerts, etc.)?	☐	☐	☐	☐
4. Ability to travel by car or bus more than 30 minutes from home?	☐	☐	☐	☐
5. Participation in social activities outside your home?	☐	☐	☐	☐
6. Emotional health (nervousness, depression, etc.)?	☐	☐	☐	☐
7. Feeling frustrated?	☐	☐	☐	☐

Items 1 and 2 = physical activity Items 3 and 4 = travel
Item 5 = social/relationships Items 6 and 7 = emotional health

Scoring: Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Reference: Uebersax JS, Wyman JF, Shumaker SA, McClish DK, Fantl JA, & the Continence Program for Women Research Group (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: the Incontinence Impact Questionnaire and the Urogenital Distress Inventory. Neurourology and Urodynamics, 14, 131-139.

______________________________ ______________
Patient Signature Date

OrthoRehab PHYSICAL THERAPY

Pelvic Floor Impact Questionnaire—short form 7 (PFIQ-7)

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Name_____ Date_____ DOB_____

Instructions: Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question, check the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark your answer in **all 3 columns** for each question.

How do symptoms or conditions in the following usually affect your	**Bladder or urine**	**Bowel or rectum**	**Vagina or pelvis**
1.Ability to do household chores (cooking, laundry housecleaning)?	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit
2.Ability to do physical activities such as walking, swimming or other exercise?	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit
3.Entertainment activities such as going to a movie or concert?	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit
4.Ability to travel by car or bus for a distance greater than 30 minutes away from home?	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit
5.Participating in social activities outside your home?	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit
6.Emotional health (nervousness, depression, etc.)	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit
7.Feeling frustrated?	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit	○ Not at all ○ Somewhat ○ Moderately ○ Quite a bit