Beyond
Therapy & Wellness

Name: ______________________________________ **DOB:** __________________ **Date:** ________________
Address: ____ **City:** _______________ **Zip:**________________
Phone: ___________________ ❑ **home** ❑ **mobile | Secondary Phone:** ___________________ ❑ **home** ❑ **mobile**
Email address: ____
How would you like to receive appointment reminders? ❑ **Text** ❑ **Automated Call** ❑ **Email**
How did you hear about us? ____

Primary Insurance Policy Holder (if not you) Name: _________________________________ **DOB:** ____________
Primary Insurance: __________________ **Secondary Ins:** __________________ **Tertiary Ins:** ________________

Age:_________ **Height:** _________ **Weight:** _________
Do you exercise regularly? If so, what type? ____
Occupation, including activities required for your job: ____
____
Are you on a work restriction from your doctor? ❑ Yes ❑ No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑ Yes ❑ No

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What are we seeing you for today? ____
What date (roughly) did your present symptoms start?____
What do you think caused your symptoms? ____
Your symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**
Treatment received so far for this problem (chiropractic, injections, etc) _______________________________
____
Please list special tests performed for this problem (x-ray, MRI, labs, etc) ______________________________
____

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: ________
The best your pain has been during the past week: ____________
The worst your pain has been during the past week: ___________

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue	❑ numbness or tingling	❑ weight loss/gain
❑ fever/chills/sweats	❑ muscle weakness	❑ headaches
❑ nausea/vomiting	❑ dizziness/lightheadedness	❑ shortness of breath
❑ cough	❑ heartburn/indigestion	❑ fainting
❑ difficulty maintaining balance while walking	❑ difficulty swallowing	❑ cough
❑ changes in bowel or bladder function	❑ ______________________	❑ ______________________

Have you or a close family member EVER been diagnosed with any of the following conditions (check all that apply to you and circle those that apply to your family history)?

❑ cancer	❑ depression	❑ thyroid problems
❑ heart problems	❑ lung problems	❑ diabetes
❑ chest pain/angina	❑ osteoporosis	❑ high blood pressure
❑ asthma	❑ multiple sclerosis	❑ circulation problems
❑ rheumatoid arthritis	❑ epilepsy	❑ blood clots
❑ other arthritic condition	❑ stroke	❑ ulcers
❑ bladder/urinary tract infection	❑ anemia	❑ kidney problem/infection
❑ chemical dependency (i.e., alcoholism)	❑ bone or joint infection	❑ hepatitis
❑ sexually transmitted disease/HIV	❑ pelvic inflammatory disease	❑ liver problems

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ALLERGIES: **Skin (latex) or medication(s):** ____

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Please list any surgeries, and or medical conditions for which you have been hospitalized, including dates:

1. ____________________________ 2. ____________________________ 3. ____________________________
2. ____________________________ 3. ____________________________ 4. ____________________________
5. ____________________________ 6. ____________________________ 7. ____________________________

Emergency Contact Information:
Name of contact: __________________________ Relationship: ______________________________
Primary Phone #: __________________________Work Phone #: _____________________________

Patient Signature: ____ Date: ________________________

Therapist Notes:

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Pelvic Floor Information:

Bladder symptoms

Do you lose urine when you:

Cough | Sneeze | Laugh: ❑ Yes ❑ No
Lift| Exercise | Dance | Jump: ❑ Yes ❑ No
On the way to the bathroom: ❑ Yes ❑ No
Have a strong urge to urinate: ❑ Yes ❑ No
Hear running water: ❑ Yes ❑ No
Do you wet the bed? ❑ Yes ❑ No
Have burning/pain with urination: ❑ Yes ❑ No
Difficulty starting a urine stream: ❑ Yes ❑ No

Strain to empty your bladder: ❑ Yes ❑ No
Feel unable to empty bladder fully: ❑ Yes ❑ No
Have a falling out feeling: ❑ Yes ❑ No
Have pain with a full bladder: ❑ Yes ❑ No
Have an urgency of urination: ❑ Yes ❑ No
(a strong urge to urinate)
Urinate more than 7 times/day: ❑ Yes ❑ No
Frequent bladder infections: ❑ Yes ❑ No

Other: ____

Bowel symptoms

Strain to have a bowel movement: ❑ Yes ❑ No
Leak and stain feces: ❑ Yes ❑ No
Include fiber in your diet: ❑ Yes ❑ No
Have diarrhea often: ❑ Yes ❑ No
Take laxatives / enema regularly: ❑ Yes ❑ No
Leak gas by accident: ❑ Yes ❑ No
Have pain with bowel movement: ❑ Yes ❑ No
Other: ____
Have a very strong urge to move your bowels: ❑ Yes ❑ No
How often do you move your bowels: _________ ❑ day or ❑ week
Most common stool consistency: ❑ Liquid ❑ Soft ❑ Firm ❑ Pellets

Please provide results for any of the following tests you had completed:

Urodynamics test results: ____
Cystoscope results: ____
Urine test results: ____
Bowel test results: ____

Do you have pain with:

Sexual intercourse and/or climax ❑ Yes ❑ No If yes, then do you have pain ❑ During or ❑ After?
Pelvic exam ❑ Yes ❑ No
Back, leg, groin, abdominal pain ❑ Yes ❑ No

FEMALE History:

Number of pregnancies: _______________
Birth weight of largest baby: ____________
Number of episiotomies: _______________

Number of vaginal deliveries _____________
Number of cesarean deliveries ___________
Date of last pap smear __________________

Did you have any trouble healing after delivery ❑ Yes ❑ No
Do you have a history of sexual abuse or trauma ❑ Yes ❑ No
Are you having regular periods/ menstrual cycles ❑ Yes ❑ No

Patient Consent

Please initial next to each patient consent statement.

_____ I hereby consent to physical therapy treatment as prescribed by my physician, or as deemed necessary by the treating physical therapist. I also understand that physical therapy treatment, by its nature, involves inherent and unavoidable risks, including falls, and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego physical therapy all together.

______ I understand I am responsible for charges incurred, regardless of insurance coverage. If Beyond Therapy & Wellness has a contract with your insurance carrier, we will file the claim. If the insurance company denies payment for no referral, non-covered services, deductible, etc, I am responsible for all balances due.

______ I assign all benefits to Beyond Therapy & Wellness PLLC that are received from my insurance provider for physical therapy services rendered.

______ It is advised that a parent or guardian attend all sessions with patients that are **minors** and I waive any claim that I may have due to my failure to comply with this advisement.

_____ I understand that Beyond Therapy & Wellness PLLC takes all actions available to keep my personal information private. I have received the Notice of Privacy Practices from Beyond Therapy & Wellness PLLC.

Cancellation Policy:

To reach your goals it is necessary for you to attend your scheduled treatment sessions. This ensures we can provide effective treatment to you and others.

If you cancel with less than 24 hours' notice it impacts 3 individuals:

1) **Yourself** – You limit your ability to reach your goals
2) **Your Therapist** –Time has been made in the therapists schedule specifically for you
3) **Another patient** – Your appointment time is not given to others that are waiting to begin PT when cancellations occur last minute.

Please call our office to cancel. Text message cancellations do not arrive within the 24 hour time window and you will get charged the $40.00 cancellation fee.

______ I understand a cancellation fee of **$40.00** will be charged to me for each appointment that is cancelled with less than 24 hours' notice.

______ I understand that text message cancellations arrive with less than a 24 hour notice and I will get charged the cancellation fee if I cancel through text.

We are happy to work with your schedule and the fee is waived when you reschedule your appointment in the same calendar week.

I certify that all information provided to Beyond Therapy & Wellness, PLLC is correct.

______________________________________ ____________________

Patient/Legal Guardian Signature Date

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I 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; persistence 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.

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.

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.

Please initial next to each patient consent statement.

_______ The purpose, risks, and benefits of this evaluation have been explained to me.

_______ I understand that I can terminate the procedure at any time.

_______ I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.

_______ I have the option of having a second person present in the room during the procedure and ❑ choose or ❑ refuse this option.

____

Patient Name

____ _____________________

Patient/Legal Guardian Signature Date