



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's/Partner 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 \_\_\_\_\_ What is the 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 and Fall \_\_\_Other

If you currently have an attorney working with you, please provide his/her name and 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 pain	___ Bladder Infection	___ Lack of Coordination	___ Epilepsy	___ Drugs/Alcohol Dependence
___ Dermatitis/Eczema /Rash	___ Hip/Upper leg Pain	___ Pelvic Pain	___ Vertigo	___ Liver/Gall Bladder Disorder	___ Depression
		___ Loss of Bladder Control			___ Other

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? \_\_\_\_\_

**Patient Signature**

Date

**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.*



# 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

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

**PATIENT INSURANCE AND AUTHORIZATION FORM**

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

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

Group # \_\_\_\_\_

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# \_\_\_\_\_

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

Male/ Female Relationship to patient: SELF SPOUSE CHILD OTHER

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

Group # \_\_\_\_\_ Phone# \_\_\_\_\_

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 recovery 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.

**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.

\_\_\_\_\_ **physicians name** \_\_\_\_\_

\_\_\_\_\_ address \_\_\_\_\_

\_\_\_\_\_ city, state, zip \_\_\_\_\_

\_\_\_\_\_ phone number \_\_\_\_\_

\_\_\_\_\_ type of doctor \_\_\_\_\_

\_\_\_\_\_ **physicians name** \_\_\_\_\_

\_\_\_\_\_ address \_\_\_\_\_

\_\_\_\_\_ city, state, zip \_\_\_\_\_

\_\_\_\_\_ phone number \_\_\_\_\_

\_\_\_\_\_ 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

Parent or legal Guardian please sign here for minor Child.

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date**

**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*