



PEDIATRIC PATIENT REGISTRATION

GENERAL INFORMATION

TODAY'S DATE	DATE OF BIRTH	FEMALE OR MALE	SOCIAL SECURITY NUMBER
PATIENT NAME (Last, First, Middle Initial)			
STREET ADDRESS		CITY	STATE ZIP
HOME PHONE NUMBER		PARENT'S EMAIL ADDRESS	
MOTHER'S NAME	OCCUPATION	EMPLOYER	EMPLOYER'S PHONE NUMBER
FATHER'S NAME	OCCUPATION	EMPLOYER	EMPLOYER'S PHONE NUMBER

How did you hear about us? Check One: Doctor _____ Advertisement/Radio _____ Internet _____
 Friend/Relative (who?) _____ Employee (who?) _____ Other _____

WHO IS FINANCIALLY RESPONSIBLE FOR TREATMENT? ___ Parent(s) ___ (Other) or Responsible Party _____

Who is your Primary Care Physician? _____

Who is your Specialty Physician? _____

Other Physician: _____

Referred By: _____
 (Name) (Profession)

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:	SECONDARY INSURANCE COMPANY:
POLICY NUMBER:	POLICY NUMBER:

POLICY HOLDER'S INFORMATION

NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
ADDRESS (if different from above)		DATE OF BIRTH
CITY	STATE ZIP	HOME PHONE (if different from above)
IS THE POLICY HOLDER CURRENTLY EMPLOYED BY THE EMPLOYER PROVIDING INSURANCE? YES NO N/A EMPLOYER NAME: _____ EMPLOYER PHONE NUMBER: _____		

EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT	PHONE #
NAME	RELATIONSHIP TO PATIENT	PHONE #

PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Your answers to the following questions will help us to manage your child's care better.

Name of parent or guardian completing this form: _____

Child's name: _____ Prefers to be called: _____

Describe the reason for your child's appointment: _____

When did this problem begin? _____ Is it getting?: Better ___ Worse ___ Staying the same ___

Name and date of child's last doctor visit: _____

Date of last urinalysis: _____ Age: ___ Grade: ___ Height: _____ Weight: _____

Previous tests for the condition for which your child is coming to therapy. *Please list tests and results:*

<u>Current Medications</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child stopped or been unable to do certain activities because of their condition? For example, can't go on sleepovers. _____

Does your child now have or had a history of the following? *Circle Y or N. Explain all "yes" responses below.*

Y/N Pelvic pain

Y/N Blood in urine

Y/N Low back pain

Y/N Kidney infections

Y/N Diabetes

Y/N Bladder infections

Y/N Latex sensitivity/allergy

Y/N Vesicoureteral reflux Grade _____

Y/N Allergies

Y/N Neurologic (brain, nerve) problems

Y/N Asthma

Y/N Physical or sexual abuse

Y/N Surgeries

Other (*please list*) _____

Explain yes responses and include dates: _____

Does your child need to be catheterized? Y/N *If yes, how often?* _____

Bladder Habits

1. How often does your child urinate during the day? _____ Times Per Day Every _____ Hours.

2. How often does your child wake up to urinate after going to bed? _____ Times

3. Does your child awaken wet in the morning? Y N If yes, how often? _____ days per week.

4. Does your child have the sensation (*urge feeling*) that they need to go to the toilet? Y N

5. How long does your child delay going to the toilet once he/she needs to urinate?

___ Not at all ___ 1-2 minutes ___ 3-10 minutes ___ 11-30 minutes ___ 31-60 minutes ___ Hour(s)

6. Does your child take time to go to the toilet and empty their bladder? Y N
7. Does your child have difficulty initiating the urine stream? Y N
8. Does your child strain to pass urine? Y N
9. Does your child have a slow, stop/start or hesitant urinary stream? Y N
10. Is the volume of urine passed usually (*circle one*): Large Average Small Very small
11. Does your child have the feeling their bladder is still full after urinating? Y N
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? Y N
13. Fluid intake (*one glass is 8 oz or one cup*): of glasses per day (*all types of fluid*)
 of caffeinated glasses per day Typical types of drinks:
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (*i.e. running water, etc.*) Y N (*If yes, please list*):

Bowel Habits

15. Frequency of movements: Per Day Per Week Consistency: Loose Normal Hard
16. Does your child currently strain to go? Y N Ignore the urge to defecate? Y N
17. Does your child have fecal staining on his/her underwear? Y N How Often?
18. Does your child have a history of constipation? Y N How long has it been a problem?

SYMPTOM QUESTIONNAIRE

1. Bladder leakage (check all that apply)
- Never
- When playing
- While watching TV or video games
- With strong cough/sneeze/physical exercise
- With a strong urge to go
- Nighttime sleep wetting
2. Frequency of urinary leakage-number (#) of episodes
- # per month
- # per week
- # per day
- Constant leakage
3. Severity of leakage (circle one)
- No leakage
- Few drops
- Wets underwear
- Wets outer clothing
4. Bowel leakage (check all that apply)
- Never
- When playing
- While watching TV or video games
- With strong cough/sneeze/physical exercise
- With a strong urge to go
5. Frequency of bowel leakage-number (#) of episodes
- # per month
- # per week
- # per day
6. Severity of leakage (circle one)
- No leakage
- Stool staining
- Small amount in underwear
- Complete emptying
7. Protection worn (circle all that apply)
- None
- Tissue paper / paper towel
- Diaper
- Pull-ups

8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10

0 _____ 10

Not a problem

Major problem

9. Rate the following statement as it applies to your child's life today: "My child's bladder is controlling his/her life."

0 _____ 10

Not true at all

Completely true

PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT OF THE PELVIC FLOOR

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. 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 or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist.

Potential benefit: I may experience 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.

Release of medical records: I authorize the release of my medical records to my physicians/primary care provider or insurance company.

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 physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy: I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of \$25.00

No warranty: I understand that the 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 opinions regarding potential results of 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. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of Integrity Rehab & Home Health.

Patient Name (Please Print)

Date

Patient Signature

Signature of Parent or Guardian (If applicable)

Witness Signature

Date