Integrity REHAB

# Adult Registration Packet
# Pelvic Floor Physical Therapy

Scan No. _____

Initials _____

PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Patient Name (Last, First, Middle Initial) | | Marital Status: M S W D<br>Circle One: Female or Male | |
| Address | | Social Security Number | Date of Birth |
| City | State Zip Code | Email Address | |
| Best Contact Number | Emergency Contact Name/Number | | |

What type of appointment reminder do you prefer? □ Email □ Phone call

What format do you prefer for your rehab documents and home exercise program? □ Email □ Printed handouts

Are you receiving any nursing, aide, or therapy services in your home? □ Yes □ No *(If yes, notify the Front Office)*

For Medicare beneficiaries, have you received therapy in this calendar year? □ Yes □ No

Is this a Workers' Comp injury? □ Yes □ No Date of Injury: _____ Adjustor: _____ Employer: _____

INSURANCE INFORMATION

| Primary: | Secondary: | Tertiary: |
|---|---|---|
| Policy/ID#: | Policy/ID#: | Policy/ID#: |
| Name of Policy Holder: | Name of Policy Holder: | Name of Policy Holder: |
| Relationship to Patient: | Relationship to Patient: | Relationship to Patient: |
| Date of Birth (Policy Holder): | Date of Birth (Policy Holder): | Date of Birth (Policy Holder): |
| SS# of Insured (Policy Holder): | SS# of Insured (Policy Holder): | SS# of Insured (Policy Holder): |
| Effective Date: | Effective Date: | Effective Date: |
| Group Number: | Group Number: | Group Number: |

Below is an estimation of benefits. It may be subject to change based on your insurance.

| | | |
|---|---|---|
| YTD Deductible $: | YTD Deductible $: | YTD Deductible $: |
| YTD Deductible Met $: | YTD Deductible Met $: | YTD Deductible Met $: |
| Co-Pay Per Visit $: | Co-Pay Per Visit $: | Co-Pay Per Visit $: |
| Estimated Co-Insurance Per Visit $: | Estimated Co-Insurance Per Visit $: | Estimated Co-Insurance Per Visit $: |
| Insurance Coverage %: | Insurance Coverage %: | Insurance Coverage %: |
| Patient's %: | Patient's %: | Patient's %: |
| Total Visits Authorized:<br>Visits Available:<br>Auth End Date _____<br>$ Limit_____<br>Are we in network? □ Yes □ No | Total Visits Authorized:<br>Visits Available:<br>Auth End Date _____<br>$ Limit_____<br>Are we in network? □ Yes □ No | Total Visits Authorized:<br>Visits Available:<br>Auth End Date _____<br>$ Limit_____<br>Are we in network? □ Yes □ No |

# Adult Medical/Pelvic Floor History (1)

Patient Name: _____
Occupation: _____
On Disability?_____On Leave?_____

Name of your Primary Care Physician: _____Location: _____
Number of people living with you: ____ Primary Language: _____ Hobbies: _____
Are you PREGNANT? ____ Yes ____ No Are you trying to get PREGNANT? ____ Yes ____ No
Check reason/s seeking therapy services:

| | | | |
|---|---|---|---|
| ____Constipation | ____Dysfunction | ____Frequency | ____Increase Muscle Strength/Tone |
| ____Improve Fitness | ____Leakage | ____Lessen Pain | ____Improve Bladder Control |
| ____Pelvic Pain | ____Prolapse | ____Urgency | ____Sexual Dysfunction |

____Other (Describe):_____

Check OTHER current symptoms you are experiencing:

| | | | |
|---|---|---|---|
| ____Fatigue Weakness | ____ Fever/Chills/Sweats | ____ Interrupted Sleep | ____ Weight Loss/Gain |
| ____Night Pain/Sweats | ____ Numbness/Tingling | ____ Nausea/Vomiting | ____ OTHER |

____Describe: _____
Please explain the problem more and tell when you first noticed the problem.

_____

Did it occur suddenly? ____ Yes ___No Did it occur gradually? ___Yes ___No
Please tell what you think may have caused the problem.

_____

| | | | | |
|---|---|---|---|---|
| How has it changed in the past year? | _____Same | _____Worse | _____Better | |
| Check Your Pain Level: | _____None | _____1-3 = low level | _____4-7 = moderate level | _____8-10 = high level |
| Describe Pain: | _____None | _____Constant Burning | _____Intermittent Ache | _____Other |

Describe: _____

Please list SPECIALISTs you have seen (Neurologist, Psychologist/Psychiatrist, Urologist, etc.)

| DATE | LOCATION | SPECIALIST | RESULTS |
|---|---|---|---|

_____

_____

Please list Diagnostic TESTS (i.e. urinalysis performed, treatments given, & exercises done for current problem):

| DATE | LOCATION | Diagnostic Tests/Treatments/Exercises | RESULTS |
|---|---|---|---|

_____

_____

Check the following conditions you are experiencing or have experienced:

| | | | |
|---|---|---|---|
| ___Abuse | ___Fibroids | ___Low Back Pain | Disease |
| ___Acid Reflux/Belching | ___Fibromyalgia | ___Osteoporosis | ___Sjogren's Syndrome |
| ___Alcohol/Drug Addiction | ___Head Injury | ___Pelvic Pain | ___Smoking History |
| ___Ankle Swelling | ___Headaches | ___Physical/Sexual Abuse | ___Sports Injury |
| ___Anorexia/Bulimia | ___Hearing/Vision Loss | ___Polycystic Ovarian Syndrome (PCOS) | ___Stress Fracture |
| ___Childhood Bladder Problems | ___Irritable Bowel Syndrome | ___Reynaud's Disease | ___TMJ Neck Pain |
| ___Chronic Fatigue Syndrome | ___Joint Replacement | ___Sacroiliac/Tailbone pain | ___Other _____ |
| ___Endometriosis | ___Latex Sensitivity | ___Sexually Transmitted | _____ |

# Adult Medical/Pelvic Floor History (2)

Patient Name: _____

Date of Birth: _____

Please list any hospitalizations, injuries, and other chron

DATE HOSPITALIZATIONS/INJURIES/SURGERIES/OTHER REASON

Please list all PRESCRIPTION (Rx) and OVER THE COUNTER (OTC) medications that you are currently taking (Include all injectable, oral, rectal, and topical MEDICATIONS): _____

FEMALES ONLY – OB/GYN History – Please complete or check the following:

Number of Pregnancies? _____ Number of Live Births? _____ Number of Vaginal Childbirths? _____

Number of Episiotomies? _____ Number of C-Sections? _____ Number of Difficult Childbirths? _____

Year(s) of Deliveries? _____

____Painful Periods _____Pelvic Pain _____Menopause - When? _____

____Painful Vaginal Penetration _____Genital Pain _____Other (Describe): _____

MALES ONLY – History – Please complete or check the following:

_____Erectile Dysfunction _____Painful Ejaculation _____Pelvic/Genital Pain (Location?)_____

_____Prostate Disorders _____Shy Bladder _____Other: _____

Check current BLADDER symptoms you are experiencing:

_____Blood in urine _____Difficulty starting _____Dribbling _____Recurrent infections

_____Constant urine leakage _____Difficulty stopping _____Intermittent/slow _____Strain to empty

_____Difficulty emptying _____Difficulty feeling urge _____Painful urination _____Other: _____

Check or complete the following BLADDER questions:

Frequency of urination: _____Times per day _____Times during the night

Length of time urine held after a normal urge to urinate: _____Not at all _____# of minutes _____ # of hours

The usual amount of urine passed: _____Small _____Medium _____Large

Frequency of BLADDER leakage: _____No leakage _____Times/day _____Times/week, ___Times/month

Activity when leakage noted: ____With cough/sneeze _____With exercise _____With strong urge to urinate

Triggers/encourage urination: ____Yes _____No _____Running water _____Hands in water

Other: _____

Check current BOWEL MOVEMENT (BM) symptoms you are experiencing:

_____Blood in stool/feces _____Diff. emptying _____Need for laxatives _____ Painful BM

_____Constipation/straining _____Diff. feeling fullness _____Support required to _____ Seepage/loss of BM

_____Diff. controlling urge _____Diff. holding gas/BM void _____ Staining of underwear

_____Other: _____

Check or complete the following BOWL MOVEMENT (BM) questions:

Frequency of BM's: _____Times per day _____Times during the night

Length of time BM held after a normal urge to defecate: _____Not at all _____# of minutes _____ # of hours

The usual amount of BM passed: _____Small _____Medium _____Large

Frequency of BOWEL leakage: ____No leakage _____Times/day _____Times/week ___Times/month
Activity when leakage noted: ____With cough/sneeze _____With exercise _____With strong urge to urinate
Triggers/encourage BM's: ____Yes _____No _____Other (Explain) _____

# Adult Medical/Pelvic Floor History (3)

Patient Name: _____
Date of Birth: _____

Rate a feeling of organ "falling out"/prolapsed or pelvic heaviness/pressure:

____None present ____Times per month ____Related to activity
____Related to menstrual period, ____When standing (for ____minutes, ____hours)
____With exertion ____Other (Describe):_____

Check and Complete all activities/events that cause or aggravate your symptoms:

____Changing positions (i.e., sit to stand) ____Light activity/housework
____No activity affects ____Sitting greater than ___minutes
____Standing greater than ___minutes ____Sexual activity:
____With cold weather: ____Vigorous activity/exercise (run/weight lift/jump)
____Walking greater than ___minutes ____With cough/sneeze/straining
____With laughing/yelling; ____With lifting/bending
____With triggers (i.e. key in door) ____With nervousness/anxiety
____Other (Describe): _____

Complete: Ways you use to relieve your symptoms_____

Activity/Exercise: 1) ___None 2) ___1-2 days/week 3) ___3-4 days/week 4) ___5+ days week
Activity Restrictions: _____
(MILLITARY: Please attach copy of recent physical restrictions)
Mental Health: 1) ___Happy; 2) ___Low stress; 3) ___Mod stress: 4) ___High stress; 5) ___Other_____

## Fluid Intake:

Problem: ____YES ____ NO

| | | | | |
|---|---|---|---|---|
| Water drinking: | ____None | ____1-3 glasses per day | ____4-6 glasses per day | ____7 or more glasses per day |
| Fruit juice: | ____None | ____1-3 glasses per day | ____4-6 glasses per day | ____7 or more glasses per day |
| Caffeinated beverages: | ____None | ____1-3 glasses per day | ____4-6 glasses per day | ____7 or more glasses per day |
| Non-caffeinated soda: | ____None | ____1-3 glasses per day | ____4-6 glasses per day | ____7 or more glasses per day |
| Other_____ | ____None | ____1-3 glasses per day | ____4-6 glasses per day | ____7 or more glasses per day |

What amount of the above fluid intake occurs between 8 am and 6 pm? ___All ___1/2 ___3/4 ___None
What fluid and how much is taken at bedtime? _____

## Please list past trials and effectiveness:

Check the way you best learn:

____Listening (discussion, lecture, CDs); ____Seeing (reading, DVD's, displays, slides);

____Doing (demonstration, practicing skill); ____Don't know

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# Adult Medical/Pelvic Floor History (4)

Patient Name: _____

Date of Birth: _____

Some find that bladder, bowel, or pelvic symptoms affect their activities, relationships, and feelings. For each question, place an X in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or pelvic symptoms or conditions over the last three (3) months. Please be sure to mark an answer in all three (3) columns for each question. Thank you for your cooperation.

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

# ADDITIONAL INFORMED CONSENT FOR ASSESSMENT, TREATMENT, AND EVALUATION OF PELVIC FLOOR DYSFUNCTION

Pelvic Floor Dysfunctions: Adult pelvic floor dysfunctions include pelvic pain syndromes, urinary incontinence, fecal incontinence, dyspareunia or pain with intercourse, erectile dysfunction, pain from an episiotomy or scarring, vulvodynia, vestibulitis, or other similar complications. Pediatric pelvic floor dysfunctions include bladder and bowel problems.

Prior to Treatment: Therapist will inform patient or caregiver of the benefits of the vaginal/rectal assessment, treatment, evaluation, and options available for a particular pelvic dysfunction. If patient/caregiver is uncomfortable with the assessment or treatment AT ANY TIME, please inform therapist, the procedure will be discontinued and alternatives will be discussed. If patient is pregnant, has an infection of any kind, has vaginal dryness, less than six (6) weeks postpartum or post surgery, has severe pelvic pain, sensitivity to KY jelly, vaginal creams, or latex, please inform the therapist prior to the pelvic floor assessment.

Assessment: Initially and periodically the therapist may perform a muscle assessment of the pelvic floor to assess muscle strength, length, range of motion, and scar mobility. Palpitation of these muscles is most direct and accessible if done via the vagina and/or rectum.

Treatment and Evaluation: The therapist will explain all treatment procedures with the patient/caregiver who may choose to participate or not participate with all or part of the treatment plan. Treatment procedures include, observation, education, and stretching and strengthening exercise In addition, treatment may include several manual techniques including palpation, massage, joint and soft tissue mobilization, ultrasound, use of vaginal weights, vaginal or rectal sensors for biofeedback, and/or electrical stimulation.

Potential Risks: There may be an increase in current level of pain or discomfort, or an aggravation of an existing injury. The discomfort is usually temporary and will probably subside in 24 hours.

Potential Benefit: There may be an improvement in symptoms and an increase in ability to perform daily activities. There may be increased strength, awareness, flexibility and endurance in movements. Decreased pain and discomfort may be experienced. In addition, a greater knowledge about managing symptoms/condition and resources will be available.

Alternatives: Available physical therapy treatment options will be explained and will be made available. Further medical, surgical, or pharmacological alternatives may be discussed with your physician or primary care provider.

Cooperation with Treatment: In order for therapy to be effective, please keep scheduled appointments and follow through with the assigned home physical therapy program.

Informed Consent: Means that the potential risks, benefits, and alternatives of therapy evaluation have been explained. Integrity Rehab therapists do not promise a cure for, or improvement, in your condition.

I have read and understand the above information. Based on the information received from the therapist, I consent to physical therapy treatment and may withdraw at any time.

Patient signature and date

Authorized agent signature and date

Relationship to patient

CONSENT FOR TREATMENT: I hereby authorize Integrity Rehab to provide therapy services to _____ that have been ordered by my (his/her) physician and are under the direct supervision of a licensed health care professional. I also understand that it is my (his/her) right to accept or refuse medical treatments.

AUTHORIZATION OF RELEASE OF INFORMATION AND PAYMENT: In applying for payment under Title XVIII or Title XIX of the Social Security Act, or other third party payer sources, I certify that the information given by me or a person authorized by me is correct. This authorization and request shall begin on _____ (TODAY'S DATE), and continue until such time that it is revoked by me, my legal representative, physician or this clinic. I also agree if there are any changes to the billing information (i.e., change in insurance company or policy, becoming ineligible or eligible for Medicare and/or Medicaid, etc.) that I will notify the clinic immediately. If I fail to report changes with my insurance to Integrity Rehab's billing department I will be financially liable/responsible. I understand that I am financially responsible for all charges that my insurance company does not pay. I authorize the release of any information necessary in order to process any billing.

RELEASE OF INFORMATION/CONFIDENTIALITY: I hereby authorize any physician, hospital/medical facility, laboratory, or other health care provider to release to Integrity Rehab any information requested by them for the purpose of continuity of care. I also authorize Integrity Rehab to release any of my (his/her) health care information from them to other health care providers involved in my (his/her) care, or any facility where I (he/she) may be admitted for the purpose of continuity of care. A written consent from patient or legal representative is required to release medical information to persons not otherwise authorized by law (federal and state). For pediatric patients I agree to the Pediatric Speech Therapy Procedures.

NOTICE OF NON-DISCRIMINATION: Integrity Rehab does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, or national origin, or on the basis of disability or age.

GRIEVANCE/COMPLAINT PROCEDURE: Should I have a grievance or complaint; I understand that every attempt will be made to rectify the situation without fear of reprisal. I may contact the Clinic Director, Compliance Officer, or Administrator by calling (254) 699-3933 or emailing Compliance@IntegrityRehab.net. If the grievance or complaint is not resolved to my satisfaction, I may follow the printed "Consumer Information Notices" in the Reception area.

PHOTOGRAPHY: I DO ___ DO NOT ___ authorize Integrity Rehab to photograph, videotape, or audio record me (him/her) for medical education or reasons related to treatment and/or promotion of Integrity Rehab operations. Patient's name will not be used.

INFORMATION RECEIVED: I have reviewed a laminated copy of the following information to read and understand: 1) Notice of Privacy Practices, 2) Cancellation and No-Show Policy, and 3) General Health Guidelines. I may request a copy to take home with me. For pediatric patients, in addition to the preceding information, I have reviewed a laminated copy of Pediatric Speech Therapy Procedures.

In addition, the following NEW PATIENT INFORMATION is available upon request:

- Abuse, Neglect, and Exploitation
- Advance Directives
- Cell Phone Policy
- Children Policy
- Civil Rights
- Disaster/Emergency
- Employee Drug Testing
- Rights of the Elderly

I acknowledge that the information above has been provided to me or is accessible to me in my primary language, or via an interpreter.
I certify that the information I have provided in this registration packet is accurate and complete.

Patient signature and date

Authorized agent signature and date

Relationship to patient