Advanced Physical Therapy

Patient Information

Therapist: _____ Account Number: _____

Social Security #: _____ Sex: ____M ____F

Patient Name: (Last) _____ (First) _____ (MI) _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home ( )_____ Work: ( ) _____

Cell: ( ) _____ E-Mail Address: _____

Date of Birth: _____ Marital Status ___M ___S ___D ___W

Patient Employer Name: _____

Occupation: _____

Emergency Contact Name: _____ Phone: _____

Referring Physician:

Have you received physical therapy this year?_____Y_____N
Are you currently receiving home health? Y N

Responsible Party Information* (Name on insurance card)

**If different than information above*

(Always "Self" for Medicare) (Always "Other" for Workman's Comp.)

Relation to Patient: ___Self ___Spouse ___Parent ___Other

Name: Last _____ First _____ MI _____

Address: _____City: _____State_____ Zip_____

Phone: Home ( )_____ Work: ( )_____ Ext:_____

Date of Birth_____ SSN: _____-_____-_____ Sex: ____M ____F

Employer: _____ Address**:** _____

City: _____ State: _____ Zip: _____

Assignment of My Benefits

For PPO. POS, Med-Pay, PIP, Lien, and Private Third Party Payers.

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

Advanced Physical Therapy of Little Rock 10014 N. Rodney Parham Ste. 100 Little Rock, AR 72227

If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

*(Please read and **INITIAL** each statement below and sign at the bottom)*

___ A photocopy of this Assignment shall be considered as effective and valid as the original.

___ I authorize the release of any medical or other information pertinent to my case to any insurance company adjuster.

___ I understand that I am financially responsible for all charges whether or not paid by insurance.

___ I understand that I am responsible to pay any co-pay and/or co-insurance at the time services are rendered and if I have an unmet deductible, I understand that I may be asked to make payments toward said deductible on each visit.

Dated this _____ day of _____, 20____.

_____ _____

Signature of Policyholder **Signature of Claimant, if other than Policyholder**

PLEASE PROVIDE INSURANCE CARD AND DRIVER'S LICENSE TO BE COPIED FOR OUR RECORDS

Informed Consent Agreement — *MUST* be completed prior to treatment.

I hereby indicate my wish to participate in the physical therapy treatment programs offered by Advanced Physical Therapy
I understand that the purpose of this program is to enhance my overall health and fitness.
I understand that dosed exercise may include aerobic conditioning, resistance training, and balance/proprioceptive training to provide cardiovascular conditioning, muscular strengthening, increased joint range of motion, and improved balance.
I understand that dosed exercise may challenge the muscle tissue, which can lead to a temporary and expected level or soreness.
I verify that my participation is fully voluntary and no coercion of any sort has been used to obtain my participation.
I have read the above information and I understand it fully and my questions concerning physical therapy procedures have been answered to my satisfaction.
I understand that I am free to deny answering any questions during the evaluation process or to withdraw from the program at any time.
I understand that the information that is obtained from this process is considered to be confidential and my respected health information is protected fully as outlined in the Statement of Privacy Notice presented to me.

_____

Patient's Signature **Date**

_____

APTC Representative Signature **Date**

Name:

Current Medication

Please list all medications you are currently taking.

1. Name of Medication:_____
Dosage:_____
Frequency:_____
How do you take your medication? (Orally, injection, etc.)_____
_____
2. Name of Medication:_____
Dosage:_____
Frequency:_____
How do you take your medication? (Orally, injection, etc.)_____
_____
3. Name of Medication:_____
Dosage:_____
Frequency:_____
How do you take your medication? (Orally, injection, etc.)_____
_____
4. Name of Medication:_____
Dosage:_____
Frequency:_____
How do you take your medication? (Orally, injection, etc.)_____
_____
5. Name of Medication:_____
Dosage:_____
Frequency:_____
How do you take your medication? (Orally, injection, etc.)_____
_____
6. Name of Medication:_____
Dosage:_____
Frequency:_____
How do you take your medication? (Orally, injection, etc.)_____
_____
7. Name of Medication:_____
Dosage:_____
Frequency:_____
How do you take your medication? (Orally, injection, etc.)____

Advanced Physical Therapy

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing you rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with the restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this constant.
- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

May we phone, e-mail or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

Information that may be disclosed? (circle all that apply): Medical Records Billing

If YES, please name the members allowed:

_____

List any other individuals or organizations this information may be released to:

_____

Information is being disclosed for the following purpose(s): _____

Unless otherwise revoked, this authorization will expire two (2) years from the dates this authorization is signed.

This consent was signed by: (**Please Print**) _____

Signature: _____ Date: _____

If Signed by legal representative, relationship to patient: _____ Date: _____

Witness: _____ Date: _____

Advanced Physical Therapy
Patient History Questionnaire

Name: _____ **DOB:** _____ **Date:** _____

Height: _____ **Weight:** _____

Describe the current symptoms that bring you to our clinic:

_____
_____
_____

When did your symptoms first begin? Have they gotten worse or better since that time?

_____
_____
_____

How has your quality of life been changed since your symptoms began?

_____
_____
_____

What treatment have you had for your symptoms? (Check all that apply):

❒ Medication: _____. Did this help? ❒ Y ❒ N

❒ Surgery: _____. Did this help? ❒ Y ❒ N

❒ Physical Therapy: _____. Did this help? ❒ Y ❒ N

❒ I have not had treatment for this problem.

GENERAL HEALTH

How many 8 oz glasses of water do you consume per day? _____
Please list all other fluids you consume, along with amount:

_____
_____
_____

Current level of stress ❒ High ❒ Medium ❒ Low
Have you ever experienced physical, emotional, or sexual abuse? ❒ Yes ❒ No
Current psychiatric therapy ❒ Yes ❒ No
Do you engage in exercise? ❒ Yes ❒ No **If so, describe type and frequency:**

_____
_____
_____

Please check all that apply regarding your medical history:

❒Type II Diabetes ❒Cardiovascular Disease ❒Low back pain ❒Chronic cough/COPD

❒Auto-immune disease ❒Other, please describe: _____

Please check all that apply regarding your surgical history:

❒ Back/spine ❒ Brain ❒ Bladder/Prostate ❒ Bones/joints ❒Abdominal organs ❒Pacemaker/Defibrillator

❒ Other, please describe: _____

URINARY HISTORY (Check all that apply):

Do you:

❒ Urinate more than once every 2 hours
❒ Have a sense of "urgency" to urinate
❒ Have difficulty initiating a urine stream
❒ Have a slow/intermittent stream of urine
❒ Have an odor associated with urine
❒ Have painful urination
❒ Have Interstitial Cystitis
❒ Have chronic urinary tract infections
❒ Wake to urinate
❒ Have difficulty emptying your bladder completely
❒ Leak urine

BOWEL HISTORY (Check all that apply):

Do you:

❒ Have daily bowel movements
❒ Have constipation (< 3 bowel movement per week)
❒ Use laxatives regularly
❒ Consume daily fiber supplements
❒ Have pain during bowel movements
❒ Have Irritable Bowel syndrome
❒ Require straining to empty bowels
❒ Leak gas or feces

Number of bladder or bowel leakage episodes per day: Bladder: _____Bowel: _____

On average, how much urine or stool do you leak? ❒ a few drops ❒ wets underwear ❒ wets outerwear ❒ wets the floor

What form of protection do you wear? Please note how many changes are required in 24 hours

❒ Tissue paper/thin liner _____ ❒ Maxi pad _____ ❒ Continence brief_____

OBSTETRIC/GYN HISTORY

Are you currently pregnant? If so, when is your due date? ❒ Yes _____ ❒ No

Date of last pap smear: _____ Date of last period: _____

Number of pregnancies: _____ Number of vaginal deliveries: ____ Number of Cesarean deliveries: ____

Number of difficult child births: ____ Number of episiotomies or vaginal tearing: ____

Please check all that apply:

❒ Menopause ❒ Painful periods ❒ Feeling that something is "falling out" of the pelvis

❒ Vaginal dryness/itching ❒ Pelvic or vulvar pain ❒ Problematic abdominal or Cesarean scar

Do you have a history of any of the following? (Check all that apply):

❒ Yeast infections ❒ Lichens Simplex ❒ Urinary tract infections

❒ Candida ❒ Lichens Sclerosis ❒ Eczema

❒ Genital Herpes or other STIs ❒ Recent change in vaginal discharge ❒ Contact dermatitis

❒ Psoriasis ❒ Other skin diagnoses: _____

CURRENT SEXUAL ACTIVITY

❒ Sexually active ❒ Sexually inactive due to pain ❒ Sexually inactive due to other reasons

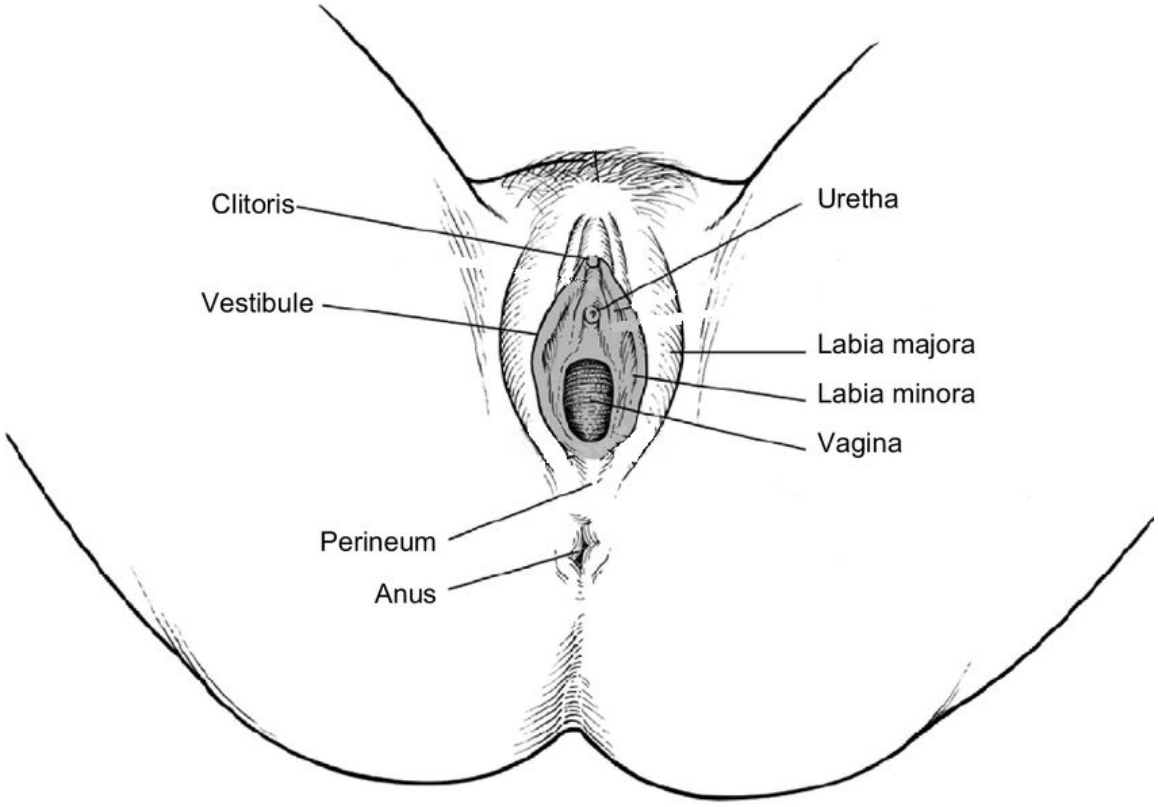
If you are sexually active, continue with this section (check all that apply):

Are you using a form of birth control? If so, please list the type and duration of use ❒ Yes ❒ No

_____

❒ No pain with intercourse
❒ No pain during intercourse, but will occur afterwards
❒ Pain with intercourse, but able to complete sex
❒ I can tolerate oral or manual stimulation only
❒ Pain with intercourse prevents sex

Please mark the areas where you feel pain. If you are not having any pain, omit the following section.



Please rate your pain on a scale from 0 - 10, with 0 being no pain and 10 being the worst pain imaginable: _____

Advanced
PHYSICAL THERAPY

PELVIC FLOOR DISTRESS INVENTORY

NAME_____ **DATE** _____

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas but please fill out both sides of this form as completely as possible.

Do you experience, and if yes, how much are you bothered by….	**Yes or No**	**Not at all**	**Somewhat**	**Moderately**	**Quite a bit**
Usually experience pressure in the lower abdomen?	**No Yes** ☐				
Usually experience heaviness or dullness in the pelvic area?	**No Yes** ☐				
Usually have a bulge or something falling out that you can see or feel in your vaginal area?	**No Yes** ☐				
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	**No Yes** ☐				
Usually experience a feeling of incomplete bladder emptying?	**No Yes** ☐				
Ever have to push on the bulge in the vaginal area with your fingers to start or complete urination?	**No Yes** ☐				

Do you experience, and, if so, how much are you bothered by…	**Yes or No**	**Not at all**	**Somewhat**	**Moderately**	**Quite a bit**
Feel you need to strain too hard to have a bowel movement?	**No Yes** ☐				
Feel you have not completely emptied your bowel at the end of a bowel movement?	**No Yes** ☐				
Usually lose stool beyond your control if your stool is well formed?	**No Yes** ☐				
Usually lose stool beyond your control if your stool is loose?	**No Yes** ☐				
Usually lose gas from the rectum beyond your control?	**No Yes** ☐				
Do you usually have pain when you pass your stool?	**No Yes** ☐				
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	**No Yes** ☐				
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	**No Yes** ☐				

Do you experience, and if so, how much are you bothered by...	Yes or No	Not at all	Somewhat	Moderately	Quite a bit
Usually experience frequent urination?	No Yes □				
Usually experience urine leakage associated with a feeling of urgency, this is, a strong sensation of needing to go to the bathroom?	No Yes □				
Usually experience small amounts of urine leakage related to coughing, sneezing, or laughing?	No Yes □				
Usually experience small amounts of urine leakage (that is, drops)?	No Yes □				
Usually experience difficulty emptying your bladder?	No Yes □				
Usually experience pain or discomfort in the lower abdomen or genital region?	No Yes □				

Urinary Distress Inventory 6 (UDI-6)