FOUNDATION PHYSICAL THERAPY

PATIENT'S NAME _____ **DATE** _____ **DATE OF BIRTH** _____

HEIGHT: _____ **WEIGHT:** _____ **lbs. (Insurance required) MARITAL STATUS: ( ) married ( ) single ( ) widowed ( ) divorced**

WORK STATUS (full, part, retired) _____ **OCCUPATION:** _____

CURRENT MEDICATIONS: (Required) _____

EMERGENCY CONTACT: _____ **PHONE ( )**_____

WHO IS YOUR PRIMARY CARE PHYSICAN? _____ PHONE ( )_____

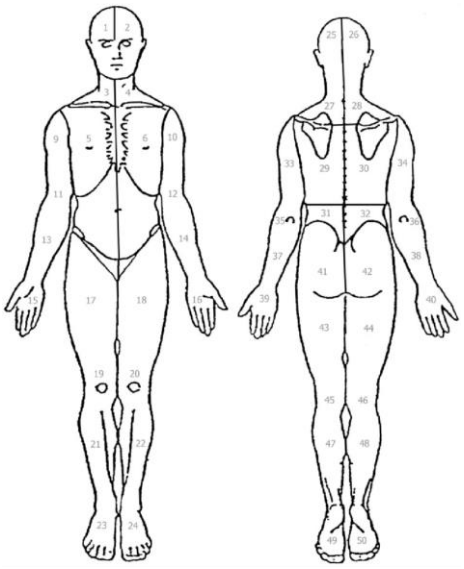
MEDICAL AND SURGICAL HISTORY: Check all that apply

MEDICAL/SURGICAL HISTORY

□ **Diabetes**
□ **Falls in the past year:** □ **No** □**Yes**
How many_____ Injury? _____
□ **Cancer where?** _____
when? _____
□**Pacemaker**
□ **Osteoporosis**
□ Circulation problems
□ Heart problems
□ High blood pressure
□ Broken bones/fracture
□ Lung problems
□ Stroke
□ Hypoglycemia/low blood sugar
□ Head injury
□ MS
□ Parkinson's disease
□ Seizures/epilepsy
□Thyroid problems
□ Infectious disease
□ Kidney problems
□ Skin diseases
□ **Depression**
□ Allergies: _____
□ Other: _____
□ Other: _____
□ Other: _____

Have you had any of the following symptoms? (Check all that apply)

□ Chest pain
□ Heart palpitations
□ Shortness of Breath
□ Dizziness or blackouts
□ Coordination problems
□ Weakness of the arms or legs
□ Loss of balance
□ Difficulty walking
□ Joint pain or swelling
□ Pain at night
□ Difficulty sleeping
□ Loss of appetite
□ Nausea/vomiting
□ Difficulty swallowing
□ Weight loss/gain
□ Urinary problems
□ Fever/chills/ sweats
□ Headaches
□ Hearing problems
□ Arthritis
□ Vision problems
□ **Any surgeries:**
_____
_____
_____
_____
_____



KEY

XX Pain
OO Tingling
ZZ Numbness

CURRENT CONDITION

-What is your current complaint for which you seek physical therapy?

_____

When did the problem begin? _____

-What happened? _____

-Have you ever had the problem(s) before?
□ **Yes**
What did you do for the problem_____
Did the problem get better? _____
How long did the problem last?_____
□ **No**

What are your goals for Physical Therapy? _____

Wong-Baker FACES Pain Rating Scale

From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Current pain level: /10

Best pain level in month: /10

Worse pain level in month: /10

2022

FOUNDATION PHYSICAL THERAPY
NOTICE of PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office with a written request. By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

-Protected health information may be disclosed or used for treatment, payment or health care operations
-The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
-The Practice reserves the right to change the Notice of Privacy Policies.
-The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
-The Practice may condition treatment upon the execution of this consent.

Please list the family members or other persons, if any, whom we may inform about your general medical condition/diagnosis:

Name: _____ Phone: _____

_____ _____
Date PRINT Patient's/Insured's Name

_____ _____
Practice Representative (WITNESS) SIGNATURE of Patient/Insured (Parent Signature if Child)

FOUNDATION PHYSICAL THERAPY **INSURANCE AUTHORIZATION**

I hereby assign all medical/physical therapy benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Foundation Physical Therapy. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am ultimately responsible for all charges, whether or not paid by said insurance. I also understand that, should I default on my account, all costs of attorney's fees, interest (18% annum or 1.5%per month) and cost of collections would be my responsibility. I hereby authorize said assignee to release all information necessary to secure payment and to complete disability forms on my behalf if necessary. In the case of returned checks, the fee charged by the bank will be added to your account. PATIENTS ARE RESPONSIBLE FOR NOTIFICATION OF ANY CHANGES WITH INSURANCE PLANS/COVERAGE. ANY PATIENTS THAT REFUSE EXERCISES, AND ONLY WANT MANUAL RX WILL BE CHARGED PRIVATE PAY.

_____ _____
Date PRINT Patient's/Insured's Name

_____ _____
Practice Representative (WITNESS) SIGNATURE of Patient/Insured (Parent Signature if Child)

FOUNDATION PHYSICAL THERAPY **PATIENT INFORMED CONSENT**

I hereby indicate my wish to be a participant in the rehabilitation program by Foundation Physical Therapy. I understand that the purpose of this program is to enhance my recovery from an injury, illness or problem. I further understand that certain changes will occur during treatment. I understand that I will be informed of the procedures and methods of treatment that will be administered to me, and understand what is required of me as a patient. I verify that my participation is fully voluntary, and no coercion of any sort has been used to obtain my participation, and I may withdraw from treatment at any time. I understand that the facility administrator, Gary Parsonis 727-784-6088 maintains an open-door policy and encourages calls Monday – Thursday 8:00-4:00 to discuss rehabilitation issues. We understand that cancellations are sometimes unavoidable, but cancellations must be 24 hours in advance or rescheduled in the same day to avoid a cancellation fee of $60.00. No show appointments will be assessed a $60.00 no show fee. If you cancel 3 or more time, we have the right to discharge you from services. **COPAYS ARE DUE AT TIME SERVICES ARE RENDERED.** THERE WILL BE A $15.00 ADDITIONAL CHARGE FOR EVERY COPAY NOT RECEIVED ON THE DAY OF SERVICE.

_____ _____
Date PRINT Patient's/Insured's Name

_____ _____
Practice Representative (WITNESS) SIGNATURE of Patient/Insured (Parent Signature if Child)

FOUNDATION PHYSICAL THERAPY **FOR MEDICARE/MEDICARE REPACEMENT S RECEIPIENTS:**

I have been informed by Foundation Physical Therapy, that Medicare will **not pay for Physical Therapy benefits if I am enrolled in Home Health Care, Hospice or receiving treatment at a skilled nursing facility.** My signature below acknowledges that I am not receiving any of these services. I will be financially responsible for any financial liability from Foundation Physical Therapy if I were receiving these services while attending PT at Foundation Physical Therapy.

_____ _____
Date PRINT Patient's/Insured's Name

_____ _____
Practice Representative (WITNESS) SIGNATURE of Patient/Insured

To Our Patients Regarding Cancellations and No-Shows and Insurance Protocol

We take cancellations and no-shows seriously at Foundation Physical Therapy.

We know that your appointments and treatments can make a difference in whether or not you are successful in your goals. Usually your referring doctor and/or your 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 therapist's instructions and we will be able to help you achieve your goals in treatment.

- **We *require* 24 hours' notice** in the event that you need to cancel your appointment. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.

- **There is a $60.00 charge for a cancellation without proper notice or if you are a No-Show.** This charge will *not* be covered by insurance and will have to be paid by you personally.

- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician. This could jeopardize your claim.

- You might need to see a therapist other than the one who normally treats you if you do change your appointment. They will review your patient chart, and the quality of care will be consistent.

- Any patient that does NOT STAY FOR THERAPY EXERCISES and wants hands on treatment only will be responsible for paying for the manual treatment self-pay. We do not bill insurances for massage treatment.

- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is improved or resolved. Either condition can seem to be a reason not to come in: 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 yard work. Neither of these conditions is legitimate as a reason not to come. If you're in pain, come in and get it fixed. If you're out of pain, now is the time that we begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, or speak to your therapist to discuss a discharge from services etc.

When you don't show as scheduled, three people are hurt: You, because you don't get the treatment you need as prescribed by the doctor and/or Physical Therapist; the therapist, who now has a space in their schedule since the time was reserved for you personally; and another patient, who could have been scheduled for treatment if you had given proper notice.

Insurance Protocol:

MEDICARE: Physical Therapy, Inc. is a Medicare Participating Foundation Provider. If you are a Medicare recipient your claim will be electronically filed. Upon receipt of payment/and or denial from Medicare, your secondary insurance will be billed as a courtesy, one time only. If there is a remaining balance after both insurance companies have been billed you will be responsible for this balance which will be provided for you in the form of a statement. Please note that we do not verify secondary insurances. Please contact your secondary insurance at the customer service number on the back of your card to verify your coverage and to see if any deductibles or co-payments apply to physical therapy charges.

COMMERCIAL INSURANCE/GROUPINSURANCE: (Insurance through your work or private insurance) Before your initial evaluation our office staff will verify your benefits. We will explain how much your insurance informed us they will cover and if there will be a co-payment, or deductible due, but is it your responsibility to understand and contact your insurance provider for details. You will be expected to pay your co-pay at the start of each visit. Please ask for a receipt upon payment if needed.

We appreciate your cooperation and understanding. We look forward to working with you to achieve your goals.

_____ _____ _____

Patient Signature **Date** Office Staff Signature

Foundation Physical Therapy, Inc.

Difficulty–Baseline

Name: _____ **Date:** _____

Instructions: Please circle the level of difficulty you have for each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

Please rate your pain level in the last 2 weeks. Fill in the blanks.

(0= no pain, 10=severe pain)

Currently: /10,

Best /10,

Worse /10

PHQ-9

FOUNDATION PHYSICAL THERAPY

Name: _____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
⑤	⑤	⑤	⑤

Foundation PT Pelvic Floor Disability Index (PFDI-20)

Please answer **0 = not present, 1= slightly, 2 = somewhat, 3 = moderately, 4 = quite a bit**

Pelvic Organ prolapse Distress Inventory 6 (POPDI-6) **/24**

Do You…	NO	YES
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal distress Inventory 8 (CRAD-8) **/32**

Do You…	NO	YES
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Pelvic Pain Index- Modified **/24**

Do You…	NO	YES
15. In the last month have you had any pain, burning or discomfort in your pelvic muscles, genitals, rectum, or bladder?	0	1 2 3 4
16. How intense is the pain, burning or discomfort in the above area?	0	1 2 3 4
17. How much have your symptoms kept you from activities you want to do?	0	1 2 3 4
18. How much do you think about your symptoms over the last month?	0	1 2 3 4
19. How often have you had pain or discomfort in any of your pelvic muscles, genitals, rectum or bladder?	0	1 2 3 4
20. If you were to spend the rest of your life with your current symptoms, how bothersome would this be to you?	0	1 2 3 4

*Do you experience urinary incontinence? (circle) yes or no (circle) Little or a lot? *Do you wear pantiliners, pads, adult diapers? (circle) *How many pads do you wear in 24 hours? _____ *How many times do you urinate in a day? _____ *How many of those are with urgency? _____ *How many times do you wake to go to the bathroom at night? _____ *How long does it take to start your flow of urine? _____ *Do you completely empty? _____ *How often do you have a bowel movement? _____/week. *Are they soft, medium or hard? (circle) *Any bowel urgency? yes or no *Are you sexually active? Yes or no *Any pain with or after intercourse? Yes or no *Do you do Kegels and squeeze your pelvic muscles on a regular basis ? Yes or no *If so, when did you start? _____

Foundation Physical Therapy

Patient Name: _____ **Date:** _____

UROGENITAL DISTRESS INVENTORY SHORT FORM (UDI-6)

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 this form as completely as possible.

Do you experience, and if so, how much are you bothered by...	Not at all	Slightly	Moderately	Greatly
Frequent urination	0	1	2	3
Leakage related to feeling of urgency	0	1	2	3
Leakage related to physical activity, coughing, or sneezing	0	1	2	3
Small amounts of leakage (drops)	0	1	2	3
Difficulty emptying bladder	0	1	2	3
Pain or discomfort in lower abdominal or genital area	0	1	2	3

/18

INCONTINENCE IMPACT QUESTIONNAIRE-SHORT FORM (IIQ-7)

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage

Has urine leakage affected your...	Not at all	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

/21

INFORMED CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred to a pelvic health therapist for an evaluation and treatment of pelvic floor dysfunction and related impairments of the pelvic girdle. I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist(s) or their trained assistant(s) to perform an internal pelvic floor muscle and pelvic girdle examination. This examination will include, but is not limited to assessment of skin condition, reflexes, muscle tone, length, strength, and endurance, scar mobility, and function of the pelvic floor region. It may be necessary to perform an internal pelvic floor evaluation by inserting a gloved finger(s) into the perineal region including the vagina and/or rectum. Treatment of the pelvic floor region and/or pelvic girdle may include, but is not limited to the following: observation, palpation, use of vaginal weights and other tools, vaginal and/or rectal sensors for biofeedback and/or electrical stimulation, heat, ice/cryotherapy, stretching and strengthening exercises, soft tissue and/or joint mobilization and education instruction. I understand that I will have the opportunity to give/revoke my consent at each treatment session. Verbal consent will continuously be obtained throughout each session and I am always in control of my own body and what is performed during sessions at physical therapy. I understand that I may request further patient education at any time during my therapy plan of care. I understand that I have the option to have a second person in the room for the pelvic floor evaluation and treatment (as described above). The second person present, besides myself and the treating/evaluating therapist, can be a friend, family member. Please indicate your preference with your initial below:

____ YES I want a second person present during the pelvic floor evaluation and treatment and will bring that person each visit after the initial exam.

____ NO I do not want a second person present during the pelvic floor evaluation and treatment.

____ I would like to discuss my options with my treating therapist prior to consenting.

Potential Risks: I acknowledge that a full pelvic floor evaluation and/or pelvic floor treatment may increase my current level of pain or discomfort, or an aggravation of my existing injury/symptoms. This discomfort is usually temporary. If it does not subside in 1-3 days, I agree to contact my therapist and/or physician. Potential Benefits: A full pelvic floor evaluation and/or pelvic floor treatment may improve my symptoms and increase my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance of my pelvic girdle muscles. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition/impairments and will be more aware of the resources available to me. No Warranty: I understand that the therapist(s) cannot make any promises or guarantees regarding a cure for improvement of my condition. I understand that my therapist(s) will share their opinion with me regarding potential results of physical therapy and will discuss all treatment options before I consent to treatment based on subjective and objective examination findings. I have informed my therapist(s) of any condition that would limit my ability to have an evaluation or treatment performed to the perineal/pelvic region including internal palpation of the vagina and/or rectum. I hereby request and consent to the evaluation and treatment to be provided. By signing below, I agree that I have read and understand the INFORMED CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT, and that I consent to the evaluation and treatment of my pelvic floor/pelvic girdle. Below I will list any concerns, requests, or stipulations necessary to proceed with evaluation and/or treatment that I have consented to:

_____

_____

Patient Name (please print) _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____

****If you are or may be pregnant, have an infection within or near the pelvic region, have an IUD or other implants, have a sexual communicable disease, are less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity or allergies to lubricant, vaginal creams, please inform the therapist(s) prior to the pelvic floor evaluation and treatment.**