Mission Peak Physical Therapy Intake- Women's Health Forms

Profile Information — Step 1 of 3

Please take a moment to fill out our online intake form before your visit.

First Name: _____

Last Name: _____

Preferred Name: _____

Prefix / Title: _____

Email: _____

Mobile Phone: _____

Home Phone: _____

Work Phone: _____

Street Address: _____

City: _____ State: _____

Date of Birth: _____

Gender: _____

Primary Care Physician: _____

Primary Care Physician Phone (if known): _____

Name of Referring Professional (if applicable):_____

Referring professional phone (if known):_____

Occupation: _____ Employer: _____

How did you hear about us? (ie. Doctor, friend, online directory drove-by, returning patient):

_____

Questionnaires — Step 2 of 3

Physical Therapy Intake Form: *This form contains a series of questions designed to help your physical therapist understand how you feel, and determine how well you are able to do your usual activities. This information will help your therapist give you the best possible care. Please answer every question as accurately and completely as you can. If your medical information changes during the course of your physical therapy care, it is your responsibility to notify your physical therapist of these changes.*

What are your goals for Physical Therapy? _____

_____

What are your symptoms? _____

_____

Describe the nature of your symptoms (check all that apply):

☐ sharp ☐ dull ☐ aching

☐ burning ☐ tingling ☐ numbness

☐ throbbing ☐ constant ☐ intermittent

Please rate your pain on a scale of 0 to 10: _____

Date of onset of symptoms: _____

How did your injury occur/symptoms begin? (ie. Childbirth, sports injury, pregnancy, lifting injury)_____

Since onset, are your symptoms getting (check one):

☐ better ☐ worse ☐ no change

Are your symptoms most aggravated (check one):

☐ In the morning ☐ In the afternoon ☐ In the evening ☐ No change related to time of day

Does your pain wake you up at night?

☐ Yes ☐ No

What aggravates your symptoms? (check all that apply)

☐ sitting ☐ standing ☐ lying down ☐ going from sitting to/from standing ☐ walking

☐ running ☐ work/household activities ☐ bending ☐ pushing/pulling ☐ lifting

☐ reaching overhead ☐ squatting ☐ kneeling ☐ repetitive activities

☐ sports/recreational activities ☐ stress ☐ coughing/sneezing

☐ menstruation ☐ sexual activity ☐ taking a deep breath

What relieves your symptoms? (check all that apply):

☐ rest ☐ ice ☐ heat ☐ massage

☐ bracing or taping ☐ exercise ☐ stretching ☐ sitting

☐ standing ☐ lying down ☐ changing positions ☐ medication

Have you experienced these symptoms in the past?:

☐ Yes. (If so, when?) _____

☐ No

☐ Ongoing

Have you had any of the following tests for your symptoms? (If yes, what were the results?)

☐ X-Ray: _____

☐ MRI: _____

☐ CT Scan: _____

☐ Arthrogram: _____

☐ Ultrasound: _____

☐ Other: _____

Medical History: (check all that apply and state specific condition when applicable):

☐ Cardiovascular: _____

☐ Pulmonary/lungs: _____

☐ Cancer (state specific type and current status): _____

☐ Diabetes: _____

☐ Bone/Joint Disorders: _____

☐ pacemaker or similar implanted device: _____

☐ Osteoporosis: _____

☐ Epilepsy/Seizure Disorders: _____

☐ Anxiety: _____

- [ ] Depression: _____
- [ ] History of headaches/Migraines: _____
- [ ] Vision problems: _____
- [ ] Hearing loss: _____
- [ ] Dizziness/vertigo: _____
- [ ] Other: _____

Medical History: Women's Health (check all that apply):

- [ ] currently pregnant (please specify due date): _____
- [ ] If applicable, are currently being monitored for any complications during your pregnancy?

_____

- [ ] Sexually Active (check box if yes)
- [ ] If applicable, please state any pain or problems with sexual activity: _____
- [ ] Date of last Pelvic Exam and any pertinent findings: _____
- [ ] Date of last Urinalysis and any pertinent findings: _____
- [ ] History of sexually transmitted diseases: _____

Medical History: Other Medical Symptoms (check all that apply):

- [ ] difficulty with bowel or bladder function
- [ ] fever/chills

☐ genital/anal area numbness

☐ numbness in both arms and legs

☐ generalized weakness

☐ unexplained weight change

☐ night pain

Please list your current medications and the conditions it treats: _____

_____

_____

Please list any known allergies: _____

Surgical History (list type of surgery and date or surgery): _____

_____

_____

Bowel and Bladder Symptoms (check any that apply):

☐ difficulty initiating stream or bowel movement ☐ no perception of bladder fullness ☐ weak, slow, or intermittent stream ☐ frequent toileting to avoid problems ☐ dribbling after stream ends ☐ pain/burning during urination or defecation ☐ blood in urine or stool

Frequency of urinary leakage (in 24 hour period): _____

Amount of urinary leakage:

☐ none ☐ few drops ☐ wet underwear ☐ other

Activities or positions associated with leakage:

☐ no leakage ☐ sitting ☐ standing ☐ lying down ☐ changing positions
☐ coughing ☐ laughing ☐ sneezing ☐ running ☐ walking
☐ on way to toilet ☐ when constipated ☐ sexual activity ☐ strong urge ☐ other

Length of time you are able to delay emptying: _____

Frequency of urination: _____

How many bowel movements per week? _____

Fluid intake (8 oz glasses) per day? _____

Prolapse or "falling out" symptoms

☐ never ☐ during menstruation ☐ pressure at end of day ☐ pressure with straining ☐

pressure with standing ☐ pressure all day ☐ other

Birth experience information (if applicable):

☐ how many children do you have? _____

☐ how old are they now? _____

☐ type of birth for each (vaginal or c-section) _____

☐ how long was the pushing phase? _____

☐ if c-section, was it planned or emergency? _____

☐ did you have an episiotomy or tear? _____

☐ did you have any other complications associated with childbirth? _____

_____

Postpartum health check (check any that apply):

☐ diastasis (abdominal separation) ☐ non-resolving hemorrhoids ☐ constipation or straining

☐ urinary incontinence ☐ urinary urgency ☐ back pain and/or pelvic girdle pain

☐ pain in other joints ☐ clicking or pain at the pubic symphysis or sacroiliac iliac joints (front and back of pelvis) ☐ difficulty breathing/shortness of breath ☐ painful intercourse ☐ depression

Are you currently receiving treatment from another health care professional? _____

_____

Do you exercise? (If yes, how often and what types of exercise?)

☐ Yes _____

☐ No

Are you currently working? (If yes, part-time/full time? If no, is your injury preventing you from working?)

☐ Yes: _____

☐ No: _____

Consents — Step 3 of 3

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

☐ I would like email notifications of new, cancelled, and rescheduled appointments

☐ Email 2 days before appointment ☐ Text Message (SMS) 24 hours before appointment

News and Special Promotions

☐ Yes, I would like to receive news and special promotions from Mission Peak Physical Therapy by email

Physical Therapy Intake form — Consents

Accuracy of Information

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information or omitting information can be dangerous to my health. It is my responsibility to inform my physical therapist of any changes in my medical condition.

☐ * I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my primary care physician and/or referring provider, including the staff members of those providers, as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties other than my primary care provider and/or referring provider and their staff members with my permission.

When applicable, I authorize the clinic, its associated health professionals, and/or my insurance company to release any information required for the purpose of evaluating and administering claims of insurance benefits and the payment of said benefits for all services rendered to me by Mission Peak Physical Therapy PLLC.

☐ * I have been received notice, read, and understand my privacy rights and practices.

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapist's day that could have been filled by another patient. As such, we require 24 hours' notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours' notice, or miss their appointment, will be charged a $50 cancellation fee. Patients who need to cancel due to personal and family emergency or sudden illness will not be charged a fee; if an emergency or sudden illness occurs, please notify the clinic as soon as possible.

☐ * I am aware of the Cancellation Policy.

Consent to Treatment

I grant permission for licensed physical therapists at Mission Peak Physical Therapy PLLC to perform such examinations and therapeutic treatments and/or procedures as may be professionally deemed necessary for appropriate evaluation and treatment of my condition.

For Minors: I (patient or legal guardian for patient who is a minor) grant permission for licensed physical therapists at Mission Peak Physical Therapy PLLC to perform such examinations and therapeutic treatments and/or procedures as may be professionally deemed necessary for appropriate evaluation and treatment of the condition of my child.

☐ * I consent to treatment as described above.

Financial Agreement

In-Network Physical Therapy Services: I understand that if Mission Peak Physical Therapy PLLC is an in-network provider with my insurance company, I authorize direct payment of my insurance benefits to be paid directly to Mission Peak Physical Therapy PLLC for all services rendered to me by Mission Peak Physical Therapy PLLC. Additionally, I understand that I am financially responsible for all co-payments, deductibles, share of costs, patient responsibilities and non-covered services as determined by my insurance plan at the time of claims processing

Out-of-Network Physical Therapy Services: I understand that as an out-of-network provider, Mission Peak Physical Therapy PLLC will require full payment at the time of service. If I would like assistance in seeking reimbursement for physical therapy services, I will request in writing for Mission Peak Physical Therapy PLLC to provide me with a superbill that I will submit to my insurance company. Mission Peak Physical Therapy PLLC will assist me in determining my out-of-network benefits but it is ultimately my responsibility to confirm what my out-of-network benefits are. I understand and agree that the entire cost of treatment provided by Mission Peak Physical Therapy PLLC is my responsibility, regardless of whether any out-of-network benefits cover part of all of said cost.

☐ * I agree.

Release of Liability

In agreeing to receive care provided by Mission Peak Physical Therapy PLLC ("Mission Peak") and to use its facilities, I agree as follows:

I fully understand and acknowledge that: (a) there are inherent risks, dangers, and hazards associated with participation in physical therapy and Pilates and the use of equipment as part of the treatment provided by Mission Peak; (b) such risks, dangers, and hazards include aggravation of symptoms, all types of physical injuries and/or illness, including, but not limited to, bodily injury, disease, strains, fractures, partial and/or total paralysis, and other ailments that could cause serious disability, and a very remote risk of death; and (c) these risks, dangers, and hazards may be caused by the negligence of the officers, representatives, agents, affiliates, or employees of Mission Peak, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. I hereby agree that my participation in physical therapy and/or Pilates and/or my use of equipment as part of the treatment provided by Mission Peak is strictly voluntary, and I may choose to not participate or use equipment or discontinue participation or use of equipment at any time. I agree to advise my physical therapist of any changes in my physical or mental health or condition. I hereby accept full responsibility and assume all risks and dangers for any harm, injury, losses, or damages that may result from my participation in physical therapy and Pilates and/or my use of equipment as part of the treatment

provided by Mission Peak, whether or not caused in whole or in part by the negligence or the conduct of the officers, representatives, agents, affiliates, and employees of Mission Peak, or by any other person. I, on behalf of myself, my personal representatives, and my heirs, hereby voluntarily agree to waive, release, discharge, defend, indemnify, and hold harmless Mission Peak Physical Therapy PLLC and all its employees, officers, agents, representatives, and affiliates for any and all claims, actions, or losses for bodily injury, property damages, wrongful death, loss of services, or otherwise arising out of my participation in physical therapy and/or Pilates and my use of any equipment. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the officers, agents, representatives, affiliates, and employees of Mission Peak Physical Therapy. I voluntarily accept and assume these risks.

- ☐ I HAVE READ THE ABOVE RELEASE OF LIABILITY AND BY SIGNING IT AGREE THAT IT IS MY INTENTION TO EXEMPT AND RELIEVE MISSION PEAK FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE, OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Signature: _____

Printed Name: _____

Date: _____

Parent/Guardian Signature: _____

Printed Name of Parent/Guardian: _____

Date: _____