



Office Use Only:

Account # _____

Today's Date _____

☐ New Patient ☐ New Case

PATIENT INFORMATION:

First Name: _____ MI: _____

Last Name: _____

Preferred Name: _____

Mailing Address: _____

City: _____

State: _____ Zip: _____

Date of Birth: _____ Gender: ☐ M ☐ F

SSN: _____

Marital Status: ☐ Single ☐ Married ☐ Other

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Employment Status: ☐ Full Time ☐ Part Time
☐ Retired ☐ Disabled ☐ Unemployed ☐ Student

Employer: _____
(IF A MINOR, LIST LEGAL GUARDIAN'S EMPLOYER)

Employer Address: _____

City: _____

State: _____ Zip: _____

Referring Physician: _____

Primary Physician: _____

Dx/Chief Complaint: _____

Next MD/DO Appt: _____

EMERGENCY/LEGAL GUARDIAN CONTACT:

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Would you like to receive e-mail reminders for you appointments? If so, give e-mail address below.

E-Mail: _____

How did you hear about us?

INSURANCE INFORMATION:

Primary Insurance: _____

Insured's First/Last Name: _____

Insured's Date of Birth: _____

Insured's SSN #: _____

Relationship To Patient: _____

Secondary Insurance: _____

Insured's First/Last Name: _____

Insured's Date of Birth: _____

Insured's SSN #: _____

Relationship To Patient: _____

Have you received any physical therapy, speech or occupational therapy since January 1st of this year from any provider (hospital, nursing home, home health, or other outpatient facility)? ☐ Yes ☐ No

If yes, where? _____

When: _____ For same condition? ☐ Yes ☐ No

RELEASE OF MEDICAL INFORMATION - HIPAA

Rebound Outpatient Physical Therapy and/or its affiliated office(s) HIPAA policies regarding the safekeeping of my personal and medical information and the notices of patient information practices have been made available to me by request and I understand this information will only be shared with my physician(s), attorney, insurance provider and/or employer in the case of a worker's compensation claim.

Rebound Outpatient Physical Therapy and/or its affiliated office(s) may also release information regarding my treatment and/or billing to the following:

Print Person's Name

Relationship

Print Person's Name

Relationship

CONSENT TO TREAT AND INSURANCE RELEASE INFORMATION

I hereby consent to the medical care and treatment procedures as determined necessary by my physician(s). I further authorize Rebound Outpatient Physical Therapy and/or its affiliated office(s) to release to my insurance company any necessary information needed to file and expedite payment on my claim. I hereby irrevocably assign and transfer to this facility any and all benefits, either contractual, common law, or statutory to which I am entitled or which are available to me under any medical, health, accident, or workers' compensation policy, plan, or program. I hereby authorize and direct that any such payments be paid directly to this facility. I further authorize and agree that a copy of this authorization shall be deemed valid as the original. ***In the event that I would fail to pay my bill, I agree to pay any additional charges related to the cost of collection fees (40%) including, but not limited to, collection agency fees, reasonable attorney fees and court costs.*** I agree to permit Rebound Outpatient Physical Therapy and their business associates to contact me by telephone at any telephone number associated with my account, in order to service the account or to collect any amounts I may owe. In the case of a returned check, there will be an additional \$35.00 charge. In consideration of our other patients, I understand, if possible, I will contact this facility in advance if I need to cancel or arrive late for an appointment. I understand if I fail to show for an appointment without notification, I may be charged a \$35.00 Missed Appointment fee for each missed visit. If I miss two (2) or more consecutive appointments without notification, all future appointments may also be cancelled. I further understand if circumstances result in my late arrival for a scheduled appointment, I may be asked to re-schedule. If I cancel two or more appointments without a 24-hour notice, I may also be subjected to the \$35.00 Late/Cancelled Appointment fee for each cancelled appointment. I acknowledge that Missed and/or Cancelled Appointment charges are my responsibility and will not be billed to my insurance provider.

I acknowledge the information provided to be accurate.

X _____
Patient/Parent/Legal Guardian Signature

Date

CONSENT:

I understand that I have been referred to physical therapy for pelvic floor dysfunction and that it may be necessary for my therapist to perform a muscle assessment and treatment of the perineal region and/or rectal canal. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist and alternative treatments will be discussed with me.

Do you have a cardiac pacemaker or other implanted electrical device? ☐ Yes ☐ No

Are you less than 6 weeks post-surgery? ☐ Yes ☐ No

Patient Signature: _____

MEDICAL CONDITIONS: (Check all that apply)

- ☐ Yes ☐ No Blood Clots
☐ Yes ☐ No MRSA
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Open Wounds
☐ Yes ☐ No Frequent Yeast Infections
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Dementia/Memory Issues
☐ Yes ☐ No Heart Problems
☐ Yes ☐ No Ankle Swelling
☐ Yes ☐ No Hemorrhoids/Anal Fissure
☐ Yes ☐ No Irritable Bowel Syndrome
☐ Yes ☐ No Fibroids/Cysts
☐ Yes ☐ No Vision/Hearing Problems
☐ Yes ☐ No Epilepsy/Seizures
☐ Yes ☐ No Depression
☐ Yes ☐ No Hyper/Hypo Thyroid
☐ Yes ☐ No Chronic Fatigue/Fibromyalgia
☐ Yes ☐ No Low Back Pain
☐ Yes ☐ No Night Pain/Night Sweats
☐ Yes ☐ No Unexplained Muscle Weakness
☐ Yes ☐ No Pudendal Nerve Irritation
☐ Yes ☐ No Digestive Problems
☐ Yes ☐ No Tail Bone/ Sacroiliac Pain

Other: _____

- ☐ Yes ☐ No Endometriosis
☐ Yes ☐ No Inflammatory Bowel/Crohn's
☐ Yes ☐ No Stroke
☐ Yes ☐ No Breathing Difficulty
☐ Yes ☐ No Numbness/Tingling
☐ Yes ☐ No Falls/Trips/Slips
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Dizziness/Fainting
☐ Yes ☐ No Anemia
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Prostate Cancer
☐ Yes ☐ No Headaches/Migraines
☐ Yes ☐ No Anorexia/Bulimia
☐ Yes ☐ No Smoking Currently
☐ Yes ☐ No Smoking History
☐ Yes ☐ No Prostatitis
☐ Yes ☐ No BPH (Enlarged Prostate)
☐ Yes ☐ No Bladder Infection
☐ Yes ☐ No Breast Cancer
☐ Yes ☐ No Ovarian/Uterine Cancer
☐ Yes ☐ No Hepatitis/HIV
☐ Yes ☐ No Sexually Transmitted Disease

Other: _____

MEDICATION LIST: (Please list prescription & nonprescription medications)

PLEASE LIST ANY ALLERGIES

SURGERIES:

Surgery	Year	Surgery	Year	Surgery	Year	Surgery	Year
Neck		Cardiac Bypass		Appendectomy		Prolapse	
Back		Cardiac Stent		Hernia Repair		Removal of Adhesions	
Joint replacement		Pacemaker		Breast Surgery		Other:	

SECTION A: BLADDER RELATED SYMPTOMS (If you do not have any bladder symptoms, skip Section A)

✓	Difficulty Voiding	✓	Pain	✓	Bladder History
	Trouble initiating urine stream		Painful urination		Shy Bladder
	Intermittent/Slow urinary system		Discomfort in bladder		Blood in urine
	Trouble emptying bladder		Pain with bladder filling		Frequent bladder infections
	Straining/Pushing to void		Decreased pain after voiding		Pelvic pressure/heaviness
	Dribbling after urination				Falling out of bladder (Cystocele)
	Can't feel urge/bladder fullness				Interstitial cystitis

URINARY FREQUENCY/URGENCY:

How often do you urinate a day? ☐ 1-3 times ☐ 4-7 ☐ 8-10 ☐ More than 10 times

How long can you delay urinating before you "just have to go"?

☐ As long as I need ☐ 30 minutes ☐ For a few minutes (5-10) ☐ Less than 5 minutes ☐ Can't hold it

How often do you wake up at night to urinate? ☐ None/Rarely ☐ Once ☐ 2-3 times ☐ More than 3 times

When you urinate, do you feel the amount is: ☐ Small ☐ Medium ☐ Large

Do you feel like you have emptied your bladder? ☐ Yes ☐ No

Are you able to stop you flow of urine by squeezing your pelvic floor muscles? ☐ Yes ☐ No

How many 8 oz glasses of water do you drink per day? _____

How many caffeinated beverages (coffee, tea, soda) do you consume daily? _____

How many alcoholic beverages (beer, wine, liquor) do you consume daily? _____ If not daily, weekly? _____

URINARY LEAKAGE: If this doesn't apply, please skip this section:

What causes leakage? ☐ Cough ☐ Sneeze ☐ Exercise ☐ Daily Activities ☐ Other: _____

What started the leakage? What started the leakage? ☐ I don't know OR: _____

How long have you had leakage? _____ Months _____ Years ☐ Other: _____

Is leakage associated with strong desire to urinate: ☐ Yes ☐ No

How often do you leak? _____ times/day _____ times/week _____ times/months
_____ only with some activities

How much do you usually leak? ☐ Drops ☐ Wets underwear ☐ Wets outerwear ☐ Wets floor

What protection do you wear? ☐ None ☐ Tissue paper ☐ Maxi pad/Absorbent pad ☐ Diaper

Have you had any treatment for this? ☐ Yes ☐ No If yes, what? _____

			If yes, how much does it bother you?			
			Not at all	Somewhat	Moderately	Quite a bit
1.	Frequent urination	<input type="checkbox"/> No	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2.	Night time urination	<input type="checkbox"/> No	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3.	Urine leakage related to the feeling of urgency	<input type="checkbox"/> No	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4.	Urine leakage related to physical activity, coughing or sneezing	<input type="checkbox"/> No	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5.	General urine leakage not related to urgency or activity	<input type="checkbox"/> No	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6.	Small amounts of urine leakage (drops)	<input type="checkbox"/> No	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7.	Large amounts of urine leakage	<input type="checkbox"/> No	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8.	Difficulty emptying your bladder	<input type="checkbox"/> No	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9.	Pain or discomfort in the lower abdominal or genital area	<input type="checkbox"/> No	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4