REBOUND
PHYSICAL THERAPY AND PELVIC HEALTH

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? _____

SECTION B: BOWEL RELATED SYMPTOMS (If you do not have any bowel symptoms, skip Section B)

√	Difficulty Voiding	√	Pain	√	Bowel History
	Constipation		Bowel discomfort/pain		Falling out bowel (Rectocele)
	Diarrhea		Pain with defecation		Irritable bowel syndrome
	Straining to empty bowels		Pain after defecation		Diverticulitis
	Trouble feeling bowel fullness				Pelvic pressure/heaviness
	Trouble feeling urge to have BM				Childhood bowel problems
	Can't empty bowels fully				

BOWEL FREQUENCY/URGENCY/CONSTIPATION:

How often do you have a bowel movement a day? □ 1-3 times □ 4-7 □ 8-10 □ More than 10 times
How long can you hold a bowel movement once you have an urge?
□ As long as I need □ 30 minutes □ For a few minutes (5-10) □ Less than 5 minutes □ Cannot tell when full
Usually, the stool is: □ Hard/Pellets □ Thin/Pencil Like □ Firm □ Soft □ Watery
When constipated how are you helping yourself: □ Laxative □ Fiber/Diet □ Drink more fluids
□ Other: _____

LEAKAGE OF STOOL OR LEAKAGE OF GAS: If this doesn't apply, please skip this section:

Is leakage associated with a strong desire to have a bowel movement? ☐ Yes ☐ No
How often do you leak a day? ☐ 1-3 times ☐ 4-7 ☐ 8-10 ☐ More than 10 times
On average, how much stool do you leak?: ☐ Stain underwear ☐ Small amount ☐ Complete emptying
What protection do you wear?: ☐ None ☐ Tissue paper/Panty Shield ☐ Maxi pad/Absorbent pad ☐ Diaper
How long have you had this problem? _____
What started the leakage? ☐ I don't know
Or list reason: _____
Have you had any treatment for this? ☐ Yes ☐ No
If yes, what? _____

SECTION C: PELVIC PAIN RELATED SYMPTOMS (If you do not have pain symptoms, skip Section C)

√	Check if applicable	√	Check if applicable
	Pudendal neuralgia		Painful sex with penetration
	Pelvic pain		Lower abdominal pain
	Pain in tailbone		Rectal pain
	Pain in low back/sacro-iliac pain		Burning in perineal area

SEXUAL PAIN/DISCOMFORT:

Please check the statement that best describes your current level of sexual activity:
☐ Sexually active without any discomfort
☐ Pain with intercourse but able to complete coitus
☐ Pain with intercourse prevents completion of coitus
☐ Pain with intercourse prevent any attempt at coitus
☐ Not sexually active due to not being in a relationship currently
☐ Not sexually active for other reasons
☐ Lack sexual desire/no interest in sex

How long have you had pain/discomfort? ☐ Months ☐ Years ☐ This question does not apply to me
Rate your pain level 0-10 (10 being the worst) 0 1 2 3 4 5 6 7 8 9 10
Describe the pain: ☐ Burning ☐ Stinging ☐ Unbearable ☐ Other: _____

Is there anything else you feel we should know that would assist your physical therapy treatment?

_____

_____

NIH-Chronic Prostatitis Symptom Index (Male)

Pain or Discomfort

In the last week, have you experienced any pain or discomfort in the following areas?

- Area between rectum and testicles (perineum) ..... ◻ YES ◻ NO
- Testicles ..... ◻ YES ◻ NO
- Tip of penis ..... ◻ YES ◻ NO
- Below your waist in your pubic area ..... ◻ YES ◻ NO
- Pain or burning during urination ..... ◻ YES ◻ NO
- Pain or discomfort during or after sexual climax (ejaculation) .....◻ YES ◻ NO
- How often have you had pain or discomfort in any of these areas over the last week?
  ◻ NEVER ◻ RARELY ◻ SOMETIMES ◻ OFTEN ◻ USUALLY ◻ ALWAYS
- Which number best describes your average pain or discomfort on the days that you had it, over the last week?
  Circle one? NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

Urination

- How often have you had the sensation of not emptying your bladder completely after you finished urinating, over the last week?
  ◻ Not at all ◻ Less than 1 time ◻ Less than half the time ◻ About half the time
  ◻ More than half the time ◻ Almost always or always
- How often have you had to urinate again less than 2 hours after you finished urinating over the last week?
  ◻ Not at all ◻ Less than 1 time ◻ Less than half the time ◻ About half the time
  ◻ More than half the time ◻ Almost always or always

Impact of Symptoms

How much have your symptoms kept you from doing the kinds of things you usually do, over the last week?

◻ None ◻ Only a little ◻ Some ◻ A lot

How much did you think about your symptom, over the last week?

◻ None ◻ Only a little ◻ Some ◻ A lot

If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

◻ Delighted ◻ Pleased ◻ Mostly satisfied ◻ Mixed (about equally satisfied and dissatisfied)
◻ Mostly dissatisfied ◻ Unhappy ◻ Terrible