New Patient Information Form

SAWTOOTH Physical Therapy

First Name _____ MI ___ Last Name _____

Date of Birth _____ Social Security # _____ Gender

Mailing Address _____ ☐ Male ☐ Female

_____

_____

Physical Address _____

_____

_____ Driver's Lic # _____

		OK To Call	Best Time To Call
Home Phone	_____	☐	_____
Work Phone	_____	☐	_____
Cell Phone	_____	☐	_____

Marital Status
☐ Divorced
☐ Separated
☐ Married
☐ Single
☐ Unknown
☐ Widowed

Employment Status
☐ Active Military
☐ Full-Time
☐ None
☐ Part-Time
☐ Retired
☐ Self Employed

Student Status
☐ Full-Time
☐ None
☐ Part-Time

Email Address _____

How would you like to receive Appointment Reminders?
☐ Text ☐ Email

Patient Employer _____
Address _____
_____
Phone _____
Occupation _____

Spouses Employer _____
Address _____
_____
Phone _____
Occupation _____

How did you hear about us?

☐ Physician
☐ Employer
☐ Case Manager
☐ Former Patient
☐ Adjustor
☐ School
☐ Hospital
☐ Cross Referral
☐ Attorney
☐ Self
☐ Screens - Open Houses
☐ Marketing Ad - Print
☐ Marketing Ad - TV
☐ Marketing Ad - Billboard
☐ Marketing Ad - Direct Mail - Email

Specify: _____ ☐ Friend/Family - Please list Name: _____

_____ _____

Signature of Patient Date

Medical History Form

Welcome to Sawtooth Physical Therapy LLC. Please take a moment to fill out your medical history as accurately as possible. Our goal is to ensure that you receive the best and most complete care possible, and this information is vital for us. Please write clearly and be aware that your therapist may verbally review this information with you.

Name: _____ Date of Birth:_____

Occupation: _____

Height_____ Weight_____

Who is your Primary Physician: _____

Would you like us to correspond with your primary care physician regarding your care here? YES NO

Who is your Referring Physician: _____

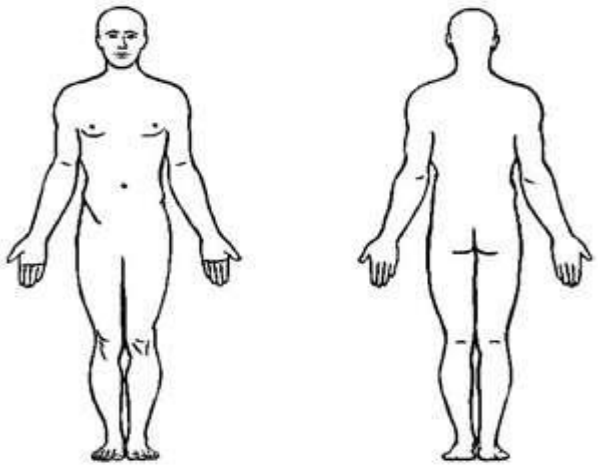
Why are you coming here today, please describe injury or condition?

_____

_____

My current pain rates from 0 (No pain) to 10 (worst pain) is: _____/10

Please use the diagram below to mark any area you are experiencing pain. Please be specific.



The primary symptoms that brought you here today interfere with quality of life? YES NO

What activities aggravate your symptoms? (Please check all that apply)

Check		Check	
	Cough/sneeze/straining		Triggers (i.e. running water)
	Laughing/yelling		Nervousness/anxiety
	Lifting/bending		No activity affects the problem
	Cold weather		Other:_____

What makes your pain worse? _____

What makes your pain better? _____

How long will your pain last? _____

Is your pain constant/intermittent? _____

How long can you comfortably…. Sit?_____ Stand?_____ Walk?_____

What activities would you like to do now but can't because of your problem?_____

_____

What are your goals for your rehabilitation? _____

Please list all prescription and over-the-counter medications you are currently taking? (Attach separate sheet if necessary)._____

_____

Please list any medications you are allergic to: _____

Are you allergic to latex: YES NO Bees or bee stings: YES NO

Do you have a pacemaker or any other implantable device: YES NO

Have you received any other medical care for this condition? If yes, by whom?

_____

Are you currently under a physician for any other conditions? If yes, what condition and by whom?

_____

Please list **ALL** surgeries and describe any other significant injuries (including sprains and fractures) and approximate dates:_____

_____

Have you fallen in the past 12 months? YES NO

If YES, how many falls or near falls have you encountered? _____

Have you recently experienced any of the following conditions?

	YES	NO		YES	NO		YES	NO
Weight Loss or Gain			Fever/Chills/Sweats			Osteoporosis		
Fatigue			Vision or Hearing Problems			Stroke		
Weakness			Balance Problems			Emphysema/Bronchitis		
Bowel/Bladder Problems			Shortness of breath			Kidney Disease		
Circulation Problems			Epilepsy/Seizures			Chemical Dependency		
Fibromyalgia			Asthma			Thyroid Problems		
Cancer			Arthritic Conditions			Diabetes		
Heart Problem			Anemia			Irritable Bowel Syndrome		
High Blood Pressure			Depression			Diverticulitis		
Hepatitis			Tuberculosis			Painful Bladder Syndrome		

ORTHOPEDIC SYMPTOMS

Do you experience any of the following?

____Low back pain
____Sacroiliac joint pain
____Tailbone pain
____Pelvic pain
____Hip pain
____Knee pain
____Ankle pain
____Abdominal pain

BLADDER

Do you experience any of the following? (Please check all that apply)

	Check		Check
Trouble initiating urine stream		Frequent urine leakage	
Urinary intermittent/slow stream		Blood in Urine	
Trouble emptying bladder completely		Painful urination	
Difficulty stopping the urine stream		Trouble feeling bladder urge/fullness	
Straining or pushing to empty bladder/bowels		Recurrent bladder infections	
Dribbling after urination		Other:_____	

Please indicate the amount of urinary leakage you experience:

No leakage	A few drops	Wets underwear	Wets outerwear	Wets floor

If you leak urine, how often does this occur? _____

Frequency of urination: Awake hours _____ times per day Sleep hours _____ times per night

When you have a normal urge to urinate, how long can you delay before having to go to the toilet?

Minutes _____ Hours _____ Not at all _____

How many pads/protection do you use in a 24 hour period? _____

The usual amount of urine passed when emptying bladder is (check one):
Small (4 sec.) _____ Medium (6-8 sec.) _____ Large (10+ sec.) _____

What form of protection do you use for leakage?
Not applicable_____ Minimal (tissue) _____ Moderate (Poise) _____ Maximum (diaper)_____

BOWEL

Do you experience any of the following? (Please check all that apply)

	Check		Check
Current laxative use		Current laxative use	
Trouble feeling bowel urge/fullness		Blood in stool	
Constipation		Straining defecation	
Diarrhea		Trouble emptying bowels completely	
Trouble holding back gas/feces		Other:_____	

Please indicate the amount of fecal leakage you experience:

No leakage	Stool smearing	Small amount in underwear	Complete emptying

What form of protection do you use for leakage? Not applicable_____
Minimal (tissue) _____ Moderate (Poise) _____ Maximum (diaper)_____

Frequency of bowel movements is: _____times per day _____times per week

Please refer to the Bristol stool chart at end of intake form to answer the next question
The average consistency of your bowel is (check one):
Type 1 ___ Type 2 ___ Type 3 ___ Type 4 ___ Type 5___ Type 6___ Type 7___

If you leak stool or gas, how often does this occur? _____

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
Minutes _____ Hours _____ Not at all _____

If constipation is present describe management techniques _____

DIETARY FACTORS
What is your average fluid intake (one glass is 8oz or 1 cup)? _____glasses per day

How many of your average glasses of fluid per day are caffeinated? _____glasses per day

Do you use a fiber/laxative? YES NO If yes, what and how often? _____

PELVIC ORGAN PROLAPSE
Frequency of feeling of organ prolapse (pelvic heaviness/pressure):
____None present
____Times per month (specify if related to activity or your menstrual period)
____With standing for _____minutes or _____hours.
____With exertion or straining
____ Other _____

Do you have to apply pressure either vaginally or externally to be able to defecate? YES NO

If so, how often? ____ Occasionally ____ Often, but not every time ____Every time

Does your prolapse affect your ability to fully empty your bladder? YES NO

If so, how often? ____ Occasionally ____ Often, but not every time ____Every time

Have you had a pelvic organ prolapse surgically repaired? YES NO If yes, when? _____

Gender Specific Medical Screening Questions

Females

Have you experienced any of the following?

	YES	NO		YES	NO
Pain with penetration during sex			History of sexual/physical abuse		
Pain with initial entry of penetration			Pain with penetration of tampons		
Pain with deep thrust			Pain with speculum		
Bleeding with or following intercourse			Other: _____		

Have you had a pelvic exam within the last 12 months? YES NO

Were your pelvic exam results normal? YES NO If no, what was found? _____

Have you had a mammogram or breast exam within the last 12 months? YES NO

Are you currently pregnant? YES NO If yes, how many weeks? _____

Are you trying to conceive? YES NO

Have you ever been pregnant? YES NO

Please list dates and delivery method:_____

_____

Did you have an episiotomy? YES NO Tearing and stitching? YES NO

Have you ever had a miscarriage? YES NO If yes, how many and when? _____

_____

During a gynecological exam, do you experience pain with insertion of the speculum? YES NO

Have you begun or completed Menopause? YES NO

Have you had a hysterectomy? YES NO

Males

Have you experienced the following?

	YES	NO		YES	NO
Pain with erection			Testicular pain		
Pain with ejaculation			Erectile Dysfunction		
History of sexual/physical abuse			Other: _____		

Have you had a prostate exam within the last 12 months? YES NO

Have you had prostate disease? YES NO

Please specify disease and treatment:_____

PLEASE READ AND SIGN THE FOLLOWING:

I authorize the payment of insurance benefits to Sawtooth Physical Therapy LLC. I authorize the release of any information to and from any medical facilities, physicians, my insurance company, and to any person listed above in the medical information release section. I further agree that a photocopy of this agreement shall be as valid as the original. My signature below acknowledges that I have been offered a copy of the **Notice of Privacy Practices** for Sawtooth Physical Therapy LLC, and have been given a copy if requested. I agree to notify the office of any changes to my address, phone number, employment, and insurance. I understand that as a courtesy to all patients in the clinic, if I am more than 10 minutes late for an appointment it may be rescheduled and if a cancelation is not made at least 24 hours prior to a scheduled appointment, a $25 dollar charge will be submitted to my account. Furthermore I understand that I will be charged $50 for not showing to an appointment and I understand that multiple No-shows' or rescheduled appointments may be grounds for discharge from physical therapy at our clinic.

I acknowledge and understand that electronic communication may be used as a form of communication to and from patients of Sawtooth Physical Therapy. I understand that I have the right to communicate electronically to Sawtooth Physical Therapy staff and therapist.

I HAVE READ THE ABOVE INFORMATION ON THIS SHEET AND HAVE AGREED:

SIGN HERE:_____DATE:_____

Patient/Guardian Signature

Financial Policy Statement

Thank you for choosing Sawtooth Physical Therapy LLC for your physical therapy needs. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

We ask that all patients read and sign the Financial Policy. All patients must have one form of picture identification such as a valid driver's license.

Insured Patients:
Sawtooth Physical Therapy LLC will bill your insurance company solely as a courtesy to you. I understand that I am responsible for the entire account, less any insurance contractual agreements, when services are rendered. **Sawtooth requires that payment of your estimated share, including contractual co-pay's be made at the time of service.** In the event your insurance company requests a refund of payments made, you will be responsible for the amount refunded to your insurance company.

I hereby authorize my health insurance company to make payment directly to Sawtooth Physical Therapy LLC for any benefits I may receive. I realize that this may not represent the full payment for services rendered and that I will be held responsible for the balance due within 90 days.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. Additionally, I understand that if I pay with a check, and it is subsequently dishonored, I will be responsible for the payment plus and bank processing fees incurred by ***Sawtooth Physical Therapy LLC.***

I authorize release of any information necessary to process my insurance claims and facilitate payment of my account by a third party.

Cash Patients:
Full Payment for services is due at the time of services are rendered.

Workers Compensation:
If you are requesting we bill "Workers Compensation" for an established claim, please be advised that should your claim be denied, you will be responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. Additionally, I understand that if I pay with a check, and it is subsequently dishonored, I will be responsible for the payment plus and bank processing fees incurred by ***Sawtooth Physical Therapy LLC.***

Patient/Guardian Signature: _____ Date: _____

Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, dysfunction or pain with bowel, bladder or sexual function, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region, including the vagina and/or rectum externally and/or internally. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar and nerve mobility and tenderness, as well as the function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, stretching and strengthening exercises, relaxation techniques, soft tissue and/or joint mobilization and educational instruction. Evaluation and treatment may result in emotional distress or discomfort, and that if I am unable to tolerate the evaluation or treatment I have the right to terminate the therapy session at any time.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the procedure.
4. I have the option of having a second person present in the room during the procedure.

I will provide a 2nd person in the room ☐ I decline having a 2nd person in the room ☐

MEDICAL INFORMATION MAY BE RELEASED TO: SPOUSE:_____

PARENT: _____ OTHER: _____

_____ _____

Patient Signature Date

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid