

# Women's Health Physical Therapy

## PATIENT INFORMATION & BRIEF HISTORY

(Federal regulations require a medical history must be included in all patient's medical records in this office)

|                    |                     |            |
|--------------------|---------------------|------------|
| Date               | Referring Physician |            |
| Patient's Name     | Age                 | Birth Date |
| Address            | City                | Zip        |
| Phone              | S.S.#               |            |
| Employer           | Phone               | Occupation |
| Employer's Address | City                | Zip        |

Do you now have or have you had any of the following:

|                          | Yes                      | No                       |                                    | Yes                      | No                       |                                | Yes                      | No                       |
|--------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|
| Diabetes.....            | <input type="checkbox"/> | <input type="checkbox"/> | Headaches.....                     | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy.....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems.....               | <input type="checkbox"/> | <input type="checkbox"/> | Previous Surgery.....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease.....       | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Disorders.....             | <input type="checkbox"/> | <input type="checkbox"/> | Hernia (vertral,inguinal,etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack.....        | <input type="checkbox"/> | <input type="checkbox"/> | Allergies to heat/ice.....         | <input type="checkbox"/> | <input type="checkbox"/> | Seizures.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker.....           | <input type="checkbox"/> | <input type="checkbox"/> | Other Allergies.....               | <input type="checkbox"/> | <input type="checkbox"/> | Metal implants.....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer... ..             | <input type="checkbox"/> | <input type="checkbox"/> | Bowel and/or Bladder problems..... |                          |                          |                                | <input type="checkbox"/> | <input type="checkbox"/> |

If yes on any above, please explain and give approximate dates

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Please list any other medical diagnosis and orthopedic injuries, past or present

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Are you presently taking medication? Yes  No  If yes, please list what medications and for what condition

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Have you had previous physical therapy or chiropractics for your present condition or for any other condition this year?

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Yes  No  If yes, state where and for what condition

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Have you had any diagnostic tests for this condition ( i.e. x-ray, MRI, CT scan, etc)? If yes, then where?

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Reason for visit today:

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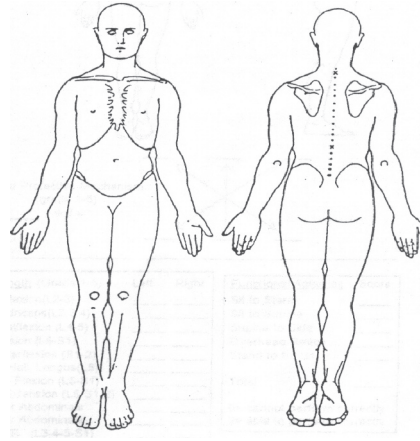


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Please mark where your symptoms are with an "X".



Describe your Pain: (*Circle all that apply*)

Aching            Throbbing            Shooting            Sharp            Tender            Unbearable  
Numb                Stabbing                Burning                Constant            Irritating            Other

Rate your pain on a scale of 0 – 10, with 10 being severe enough for hospitalization: \_\_\_\_\_

My pain/symptoms are worse when I: (for example: position, activity)  
\_\_\_\_\_

My pain/symptoms are better when I: (for example: position, activity)  
\_\_\_\_\_

My symptoms are better in the morning \_\_\_\_\_ evening \_\_\_\_\_ with movement \_\_\_\_\_ with rest.

Anything else that you want to tell me?:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Signature  
\_\_\_\_\_



**ASSIGNMENT OF INSURANCE BENEFITS**

**Patients with Medicare coverage:**

I request that payment of authorized **Medicare benefits** be made on my behalf to **Brande Moffatt, MPT, Women's Health Physical Therapy** for any services furnished me by the physicians/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents of any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer of agency shown.

In Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is responsible only for the deductible coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**Patients with private insurance coverage:**

I hereby authorize payment of medial benefits to **Brande Moffatt, MPT, Women's Health Physical Therapy** for all insurance benefits otherwise payable to me. I understand I am financially responsible for all charges NOT covered by this assignment.

\_\_\_\_\_  
Name of Insured

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Date

**Brande Moffatt, MPT**  
**Women's Health Physical Therapy**

**CANCELLATION POLICY**

Notice to ALL patients:

Please keep in mind that your appointment time is reserved for you and prevents the Therapist from seeing someone else. Therefore, if you miss an appointment without notifying us 24 hours in advance before your appointment you will be charged the full cash fee of \$ 25.00. This will not be covered by your insurance company.

I have read, understand and agree to the above terms:

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Patient Signature

## **CONDITIONS AND CONSENT FOR PHYSICAL THERAPY**

### 1. COOPERATION WITH TREATMENT:

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 understand that I may be discharged from physical therapy if I do not keep three (3) appointments without calling to cancel.

I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss them with my therapist.

### 2. NO WARRANTY:

The physical therapy department does not promise a cure for my condition. They will share with me the available statistics and studies regarding results of physical therapy treatment for my condition. They will discuss all treatment options with me.

### 3. INFORMED CONSENT TO TREATMENT

The term “informed consent” means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you. The department provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition.

#### **Potential Risks:**

You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is temporary and will probably subside in 24 hours.

#### **Potential Benefits:**

These include an improvement in your symptoms, an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain. You will have greater knowledge on managing your condition and the resources available to you.

#### **Alternatives:**

All physical therapy treatment options available for your condition will be explained to you. You may inquire on the cost of these services and discuss them with your therapist. If you do not wish to participate in the program, you may discuss your medical, surgical or pharmacological alternatives with your physician.

Based on the information I have received from the therapist, I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

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**Patient's Signature**

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**Therapist's Signature**

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**Date**

## **INFORMED CONSENT FOR ASSESSMENT OF THE PELVIC FLOOR**

I understand that if I am referred to physical therapy for pelvic floor dysfunction, it may be beneficial for my therapist to perform a *muscle assessment of the pelvic floor*. Palpation of these muscles is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain, urinary incontinence, fecal incontinence, dyspareunia or pain with intercourse, pain from episiotomy or scarring, vulvodynia, vestibulitis or other similar complications.

I understand that the benefits of the vaginal/rectal assessment will be explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

Treatment procedures for pelvic floor dysfunctions include biofeedback, electrical stimulation, use of vaginal weights and several manual techniques including massage. The therapist will explain all these treatment procedures to me and I may choose to not participate with all or part of the treatment plan.

Based on the information I have received from the therapist, I voluntarily agree to the standard assessment and treatment plans for my condition.

\_\_\_\_\_  
Patient's Signature and date

\_\_\_\_\_  
Therapist's signature.

*\*\*\*If you are pregnant, have infections of any kind, have vaginal dryness, are less than 6 weeks post partum or post surgery, have severe pelvic pain, sensitivity to KY jelly, vaginal creams or latex, please inform the therapist prior to pelvic floor assessment.*

Origin 6/96 pt-fth  
Rev 11/96 pt-fth