Name: _____ Phone #: _____

Address: _____

Preferred name if different from insurance/ID: _____

Pronouns (circle): She/Her He/His They/Them Other: _____

SS number: _____ DOB: _____ Height: _____ Weight: _____

Emergency contact/relationship: _____ Phone #: _____

Occupation, including activities that comprise your workday: _____

Leisure activities, including exercise routines:_____

Circle appropriately

Are you latex sensitive? **YES NO** Do you smoke? **YES NO**

Do you have a pacemaker? **YES NO** Do you have hearing loss? **YES NO**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

ALLERGIES: List any allergies: _____

_____

Describe the problem that brough you here: _____

_____

What date (roughly) did your present symptoms start? _____

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

Have you had prior treatment for this condition? _____

_____

Have you RECENTLY noted any of the following (check all that apply)?

❑ Fever/Chills
❑ Unexplained weight change
❑ Dizziness or fainting
❑ Change in bowel/bladder function
❑ Other/describe:
❑ Unexplained fatigue/tiredness
❑ Unexplained muscle weakness
❑ Night pain/sweats
❑ Numbness or tingling

_____

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ Cancer
❑ Heart problems
❑ High Blood Pressure
❑ Ankle Swelling
❑ Anemia
❑ Low Back Pain
❑ Sacroiliac/Tail Bone Pain
❑ Alcoholism/Drug Addiction
❑ Childhood Bladder Problems
❑ Anorexia/Bulimia
❑ Vision Eye Problems
❑ Stroke
❑ Seizures
❑ Neurological Disorder
❑ Osteoporosis
❑ Arthritis
❑ Fibromyalgia
❑ Chronic Fatigue Syndrome
❑ Joint Replacement
❑ Asthma
❑ Thyroid Problems
❑ Headaches
❑ Diabetes
❑ Irritable Bowel Syndrome
❑ Hepatitis
❑ HIV/AIDS
❑ Sexually Transmitted Disease
❑ Urinary Tract Infections
❑ Physical or Sexual Abuse
❑ Pelvic Pain or Pelvic Inflammatory Disease
❑ Other: _____

Circle appropriately

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ diabetes	❑ tuberculosis
❑ heart problems	❑ stroke	❑ thyroid problems
❑ high blood pressure	❑ depression	❑ blood clots

Please list all medications/supplemets you are currently taking: (including dosages and frequency):

-Blood Pressure Medication	-Heart Medication	-Anti-coagulants (blood thinners)
_____	_____	_____
-Muscle Relaxants	-Pain Killers	-Diabetes Medication (i.e. insulin)
_____	_____	_____
-Steroids	-Anti-inflammatories	-Other Medications (state condition)
_____	_____	_____

List any abdominal, pelvic, spine or hip surgeries with approximate dates: _____

_____

Check any symptoms that apply to you:

❑ Trouble initiating urine stream	❑ Painful urination
❑ Urination stream slow/stops & starts	❑ Trouble feeling bladder urge / fullness
❑ Trouble emptying bladder completely	❑ Trouble feeling bowel urge / fullness
❑ Difficulty stopping urine stream	❑ Constipation / straining
❑ Straining or pushing to empty bladder	❑ Use of laxatives
❑ Dribbling after urination	❑ Trouble holding gas / feces
❑ Blood in urine	❑ Recurrent bladder infections

❑ Urine leakage – If yes, how much?..... ❑ Drops ❑ Small ❑ Complete bladder loss

❑ Use of pads / diapers for any leakage? If yes, how many per day? _____

❑ Feeling of bulge or “falling out” in or around the genitals

❑ Have to splint or manually evacuate stool from rectum

How frequently do you urinate throughout the day? _____

Do you wake at night to urinate? ❑ Yes ❑ No If yes, how much _____

How frequently do you have a bowel movement? _____

How much water do you think you drink per day? Oz., glasses, bottles: _____

Are you currently sexually active? (does not include intercourse) ❑ Yes ❑ No

Are you using any form of contraceptive / birth control? ❑ Yes ❑ No If yes, what type: Oral, IUD, condoms, abstinence, diaphragm, etc): _____

List any recent pelvic exam(s) or test(s) /measures for urinary or bowel function. Ex.: urinalysis, manometry, defecogram, cystometry, ultrasound: _____

_____

Do you get any abdominal, back, pelvic, genital, or rectal pain with daily activities? ❑ Yes ❑ No

If yes, where? _____ Rate on the following scale, 0 = no pain 10 = the worst

0 1 2 3 4 5 6 7 8 9 10

IF APPLICABLE:

List any and all pregnancies **/ deliveries and complications you have had:**

Year	**Mode of delivery (vaginal or cesarean)?**	**Please list any COMPLICATIONS (es: forceps, suction/vacuum), EPSIOTOMIES, TEARING, SHORT OR PROLONGED LABOR**

Have you had any abortions or miscarriages? _____

Painful periods? ❑ Yes ❑ No

Vaginal dryness? ❑ Yes ❑ No

Menopause? ❑ Yes ❑ No

IF APPLICABLE:

Prostate disorders? ❑ Yes ❑ No

Erectile dysfunction? ❑ Yes ❑ No

Painful ejaculation? ❑ Yes ❑ No

What are your goals or hopes for physical therapy? _____

_____

I certify that the above information is accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature – Relationship to Patient *(Date)*

Consent to Treat

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.
2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility.
3. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.
4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.
5. Worker's Compensation - I hereby authorize Pappas Physical and Hand Therapy/OPT to receive my records related to my work injury.

Photo/Video Authorization

I grant to Pappas Physical and Hand Therapy/OPT and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical/occupational therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation, therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

☐ Agree or ☐ Decline

Notice of Privacy Practices

By signing this form, I acknowledge that Pappas Physical and Hand Therapy/OPT has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Pappas Physical and Hand Therapy/OPT Specialists representatives.

Communication: I authorize PPHT/OPT to communicate with me via **Email** and/or **Text message**.

EMAIL: _____ Cell phone number: _____

Is the reason for therapy the result of an MVA or Work-Related Injury? ____Yes, date_____ ____No

Have you had other therapy this year? ____Yes How Many? _____ ____No

Have you had Home Health Care? ____Yes If yes, D/C Date: _____ ____No

Release of Information

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name	Relationship

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

_____ _____

Patient/Guardian Signature – (relationship to patient) Date

Pappas | OPT

Physical, Sports and Hand Therapy