Outpatient Registration Form

Today's Date:	Last Name:	First Name:	Middle Init.	Gender
Maiden Name:	DOB:	Marital Status:	Race/Ethnicity:	Religion:
Social Security #:	Primary Care Physician:	What language do you wish to discuss your healthcare in?		
Home Address	Apt #	City	State	Zip Code
Home Telephone #	Cell Phone #	Email Address ____________ ☐ Check this box if you DO NOT want to be contacted via email regarding our services.		
Employer's Name: ____________ *(Please check which applies)* ☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐ Student			Employer's Telephone #	

Primary Ins Holder/Sponsor's name <u>and</u> relationship:	Insurance company:
Date of Birth:	Holder/Sponsor's SSN:
Secondary Ins Holder/Sponsor's name <u>and</u> relationship:	Insurance company:
Date of Birth:	Holder/Sponsor's SSN:
Third Ins Holder/Sponsor's name <u>and</u> relationship:	Insurance company:
Date of Birth:	Holder/Sponsor's SSN:

Emergency Contact Name	Relationship	Home Telephone #	Cell Phone #
Emergency Contact Employer's Name			Work Telephone #

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Medical History / Subjective Information - Pelvic Health

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Different identity (specify): ________________

Preferred Pronouns: ________________

Date of symptom onset and **describe** your symptoms? ____

____

Do you have problems with **bladder control**? **YES** **NO** **Bowel control**? **YES** **NO**

Have you ever had any **adverse sexual experiences**? **YES** **NO**

Date of your last **pelvic exam**: __________________ Date of **last urinalysis**: __________________

Date of your last **prostate exam:** N/A _________________

Special Tests? **YES** **NO** If Yes, Date and Type: ____

Have you had **surgery** for this condition **or other pelvic/abdominal surgeries/procedures**? **YES** **NO**

If Yes, Date(s) and Type(s): ____

Have you had **injections** for your condition? **YES** **NO** If Yes, Date: ______________________________________

Are you sexually active? **YES** **NO** Are you pregnant or attempting pregnancy? **YES** **NO** **N/A**

Number of past pregnancies? N/A ___________ Complications? **YES** **NO**

If Yes, describe: ______________________________________

History of, or present sexually transmitted infections? **YES** **NO**

Do you have problems with sexual activity or urination? **YES** **NO**

If Yes, describe: ____

Have you ever been taught how to do **pelvic floor or Kegel exercises**? **YES** **NO**

If Yes, when and by whom? ____

How often do you perform pelvic floor exercises? ____

GENERAL QUESTIONS:

Have you had any **falls** in the past 3 months? **YES** **NO** If Yes, when? ___________________________________

Do you worry about falling? **YES** **NO** Do you have dizziness? **YES** **NO**

What type of **non-work** activities are you involved in? ____

When are you scheduled to see your doctor again? ____

How would you rate your overall health status (check one) ? **Poor** **Fair** **Good** **Excellent**

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Medical History / Subjective Information - Pelvic Health

Circle the answer below that best fits your symptoms:

1)	**Occurrence of Incontinence or Leakage**	Never	Less than 1x/month	More than 1x/ month	Less than 1x/week	More than 1x/week	Almost everyday	# of leaks per day: ______
2)	**Protection worn**	None	Pantishields	Minipad	Maxipad	Diaper/Serenity		
3)	**Severity**	Few drops	Wet underwear	Wet outerwear				
4)	**Position or activity with leakage**	Lying down	Sitting	Standing	Changing positions (sit-stand)	Sexual activity	Strong Urge	
5)	**How long can you delay the need to urinate**	Indefinitely	1+ hours	½ hour	15 min	<10 min	1-2 min	Not at all
6)	**Activity that causes urine loss**	Vigorous activity	Moderate Activity	Light activity	No activity	Type, if applicable:		
7)	**Prolapse (falling out feeling)**	Never	Occasional with menses	Pressure at end of day	Pressure with straining	Pressure with standing	Perineal pressure all day	
8)	**Frequency of Urination (Day)**	0 times	1-2 times	5-8 times	9-12 times	13+ times		
9)	**Frequency of Urination (Night)**	0 times	1 time	2 times	3 times	4+ times		
10)	**Fluid Intake (include all beverage types)**	(9+) 8oz glasses per day	(6-8) 8oz glasses per day	(3-5) 8oz glasses per day	(1-2) 8oz glasses per day	No water		
11)	**Frequency of bowel movements**	2 times per day	1 time per day	Every other day	Once every 4-7 days	Weekly	Other:	
12)	**After starting to urinate can you completely stop the urine flow?**	Can stop completely	Can deflect urine stream	Can partially deflect stream	Cannot stop stream			
13)	**Do you have trouble initiating a urine stream?**	Never	Less than 1x/month	More than 1x/ month	Less than 1x/week	More than 1x/week	Almost everyday	
14)	**Attitude towards symptoms**	No problem	Minor inconvenience	Slight problem	Moderate problem	Major problem		
15)	**Confidence in controlling your symptoms**	Complete confidence	Moderate confidence	Little confidence	No confidence			

Is pain a symptom you are experiencing? **YES** **NO**

If YES, complete below PAIN QUESTIONS, **if NO** skip to end of survey

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Medical History / Subjective Information - Pelvic Health

PAIN QUESTIONS

Please rate your pain using a 0-10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset _________ Lowest pain since onset ________ **Today's** pain _________

Is your pain? **Constant** **Intermittent**

What makes your pain/problem **better**? ____________________________ **Worse**? ____________________________

Do you have pain with any of the following activities (circle all that apply)?

1)	**Sitting/Driving**	No Pain	Minimal Pain	Moderate Pain	Severe Pain	Unable	N/A
2)	**Standing**	No Pain	Minimal Pain	Moderate Pain	Severe Pain	Unable	N/A
3)	**Stair Climbing**	No Pain	Minimal Pain	Moderate Pain	Severe Pain	Unable	N/A
4)	**Impact Exercise**	No Pain	Minimal Pain	Moderate Pain	Severe Pain	Unable	N/A
5)	**Going from sit to stand**	No Pain	Minimal Pain	Moderate Pain	Severe Pain	Unable	N/A
6)	**Using tampons**	No Pain	Minimal Pain	Moderate Pain	Severe Pain	Unable	N/A
7)	**Sexual relations**	No Pain	Minimal Pain	Moderate Pain	Severe Pain	Unable	N/A
8)	**Moving in bed**	No Pain	Minimal Pain	Moderate Pain	Severe Pain	Unable	N/A
9)	**Urination/defecation**	No Pain	Minimal Pain	Moderate Pain	Severe Pain	Unable	N/A

Any **additional comments or concerns** you'd like to address that have not been asked? **YES** **NO**

____

____

Therapist Notes:

____

____

____

To the best of my knowledge and belief, the information I have given is complete and true.

Patient Signature: ____________________________ **Date:** __________ **Time:** ____________

PT Signature: ____________________________ **Date:** __________ **Time:** ____________

Patient Summary List

Patient Name: ______________________________ **DOB:** _____________

Allergies or Drug Allergies	Reaction/Symptoms when allergy occurs	For Clinician Use Only If new, initial and date

❑ Check this box if you are NOT currently taking any medications.

Current Medication List (include OTC and herbal)	Dosage	Frequency	For Clinician Use Only		
			New	D/C	Date/Initials

Medical History (check all that apply)

_____ Weight change of more than 10 lbs recently

_____ Heart Disease
_____ Fibromyalgia
_____ HIV/AIDS
_____ Depression
_____ Osteoporosis
_____ Ehlers-Danlos synd.
_____ Multiple Sclerosis (MS)

_____ Diabetes
_____ Tuberculosis
_____ Arthritis
_____ Pacemaker
_____ Thyroid Problems
_____ Alcohol Use
_____ Other (please explain): ____

_____ High Blood Pressure
_____ Visual Impaired
_____ Hearing Impaired
_____ Latex Allergy
_____ Pregnant
_____ Tobacco Use

_____ Asthma
_____ Epilepsy
_____ Cancer
_____ Scoliosis
_____ Stroke
_____ Hepatitis

Additional/New Medical History	If new, Clinician Initial/Date	Surgical/Invasive Procedure History	Date of Procedure	If new, Clinician Initial/Date

**** Patient Signature:** ____________________________ **Date:** _____________ **Time:** _____________

Therapist signature: ____________________________ **Date:** _____________ **Time:** _____________

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Personal Representative and Information Form

I,_________________________________, authorize Bon Secours Outpatient Rehabilitation Services to release information about my medical care to:

____________________________________ ____________________________________
(Relationship)

____________________________________ ____________________________________
(Relationship)

I understand that I must notify Bon Secours Outpatient Rehabilitation Services in writing in order to terminate this designation. I also understand that Bon Secours Outpatient Rehabilitation Services is not responsible for information that is re-disclosed by the above named individual(s).

_________________________________ ____________________ __________________
(Patient's signature) (Date) (Time)

Date of Accident/Incident or Onset of Recent Symptoms	**Type of Incident:** ☐ **Auto** ☐ **Work** ☐ **No Accident** ☐ **Other:** _______________

Would you like information in reference to financial assistance? Yes No

Do you have transportation issues which may prevent you from attending your therapy? Yes No

General Communication Preferences

Please circle your preferred method for communication with our department. If you are not a current MyChart user, please ask our staff for more information. MyChart is our preferred method of communication for appointments and unexpected clinic closures. You can also view your medications, test results, medical bills, price estimates, and more all in one place.

Communication	Mail	Phone	Text Message	Email	MyChart
MyChart Account Management					
Appointments					
Billing					

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9-2021

Bon Secours

In Motion Physical Therapy

Patient's Responsibilities

Welcome to In Motion Physical Therapy! Thank you for choosing this facility for your rehabilitation.

We look forward to serving you with the highest quality of care available. The following information is to help ensure you, and other patients, have an enjoyable therapy experience.

- If you need to **cancel or reschedule an appointment, please call us at least 24 hours in advance** so that we may open that appointment up to other patients.
- It is important for you to be on time for your appointments. **If you are late, your therapy session may be cut short, or we may have to reschedule your appointment.**
- **If you miss three or more appointments,** you may be **discharged from therapy** services and your physician will be notified.
- **Worker's Compensation patients—**all cancellations and no-shows will be documented and your adjuster/case manager and employer will be notified.
- Your therapist will give you some instructions/exercises for home. **It is important that you follow these instructions to achieve the maximum benefit from therapy.** Your family should be involved in your care if you require assistance at home.
- Periodically and upon completion of your therapy, we will send progress notes to your physician with recommendations. Together, your therapist, your physician and you will decide when you have reached the maximum benefit from your rehabilitation. **Remember: Simply because your physician writes you a prescription for therapy does not guarantee payment from your insurance company.** We must show objective and functional improvement in an appropriate time frame; otherwise, we are mandated to discharge you from therapy.
- Therapy is performed in an open gym setting. Your therapist may use a curtained treatment area or a private treatment room if increased privacy is necessary.
- Please notify your therapist, the front office or another staff member if you are dissatisfied with your level of care so that we may remedy the situation.
- Out of respect for your privacy and that of other patients, please refrain from using your cell phone during your visit.

Thank you for giving us the opportunity to serve your rehab needs. We look forward to helping you achieve your goals and providing you excellent care.

Patient Signature　　　　　　　　　　　　Date　　　　　　　　　　　　Time

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Bon Secours In Motion Physical Therapy

PELVIC FLOOR 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, difficulty with bowel, bladder or sexual functions, 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 thereafter, to have my therapists 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. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Although I am providing my consent to such evaluation and treatment, I understand that I will have the opportunity to revoke my consent at each treatment session.

Treatment may include, but is not limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I understand that I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. Although this discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.
Potential benefits: I understand that I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me to do so.
Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physical therapist, referring physician or primary care provider.
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 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. If there are any conditions that may limit my ability to have this evaluation and treatment, I will discuss that information with my therapist. I further agree that if I am pregnant, have an infection of any kind, have vaginal dryness, am less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity to lubricant, vaginal creams or latex, I will inform the therapist prior to the pelvic floor assessment.

I have read and understand the information above. I have had an opportunity to ask questions and have had those questions answered. I hereby request and consent to the evaluation and treatment to be provided as described in this form.

____
Patient Name (please print)

____________________________________ Date ____________ Time_______________
Patient (Patient Representative) Signature

____________________________________ Date ____________ Time_______________
Witness Signature

Bon Secours In Motion Physical Therapy

Plan of Care Agreement

My diagnosis, evaluation findings including the treatment program, the expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program, has all been explained to me. My questions about my care have been answered to my understanding and satisfaction. I consent to the recommended course of treatment**.**

For optimum care and progress:

- **It is important to keep your regularly scheduled therapy appointment. At those visits we can advance your exercise routine.**
- **Please avoid practicing your pelvic floor exercises just before your next appointment time.**
- **Bring your exercise sheets, voiding log and biofeedback internal sensors as appropriate to each visit.**

____
Patient Name (please print)

______________________________ ____________ ____________
Patient (Patient Representative) Signature Date Time

______________________________ ____________ ____________
Therapist Signature Date Time