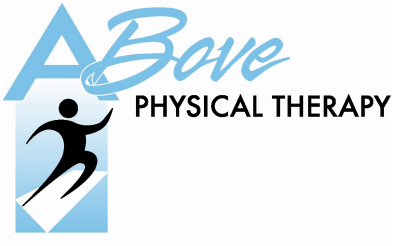

Patient Registration

(Please complete all pages. Thank you.)

PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)		EMAIL ADDRESS	
ADDRESS		SOCIAL SECURITY NUMBER	DATE OF BIRTH
CITY STATE ZIP			
HOME TELEPHONE NUMBER	CELL TELEPHONE NUMBER	WORK PHONE NUMBER	MALE FEMALE (circle one)
FAMILY PHYSICIAN	MARTIAL STATUS	OCCUPATION/EMPLOYER	

Would you like to join our email list to receive news, updates and specials? Yes/No

How did you hear about us? Check one. Doctor ____ Advertisement _____
Friend/Relative (who?)_____ Other_____

WHO IS FINANCIALLY RESPONSIBLE FOR TREATMENT?

___Myself ___ My Spouse ___My Parent(s)

INSURANCE INFORMATION

Primary Insurance Company:	Secondary Insurance Company:

Please give your insurance card/cards to the receptionist so they can make a copy for your record.

POLICY HOLDER'S INFORMATION (If **NOT** the patient)

NAME RELATIONSHIP TO PATIENT	EMPLOYER
ADDRESS (if different from above)	DATE OF BIRTH
CITY STATE ZIP	HOME TELEPHONE (if different from above)

EMERGENCY CONTACT

NAME (Last, First, Middle Initial)	RELATIONSHIP TO PATIENT
ADDRESS CITY STATE ZIP	TELEPHONE #

Patient History

1. Describe the current problem that brought you here?
   _____
   _____
2. When did your problem first begin? ___months ago or ____ years ago.
3. Was your first episode of the problem related to a specific incident? Yes/No
   Please describe and specify date
   _____
   _____
4. Since that time is it: staying the ___ same _____ getting worse_____ getting better. Why or How?
   _____
5. If pain is present rate pain on a 0-10 scale, 10 being the worst._____ Describe the nature of the pain (i.e. constant burning, intermittent
   ache)_____
   _____
6. Describe previous treatment/exercises
   _____
   _____
7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply.
   ___Sitting greater than_____ minutes
   ___Walking greater than_____ minutes
   ___Standing greater than_____ minutes
   ___Changing positions (i.e. – sit to stand)
   ___Light activity (light housework)
   ___Vigorous activity/exercise (run/weight lift/jump)
   ___Sexual activity
   ___Other, please list _____
   ___With cough/sneezes/straining
   ___With laughing/yelling
   ___With lifting/bending
   ___With cold weather
   ___With triggers –running water/key in door
   ___With nervousness/anxiety
   ___No activity affects the problem
8. What relieves your symptoms?
   _____
   _____
9. How has your lifestyle/quality of life been altered/changed because of this problem?
   Social activities (exclude physical activities), specify_____
   Diet/Fluid intake, specify_____
   Physical activity, specify_____
   Work, specify_____
   Other_____
10. What are your treatment goals/concerns?
    _____
    _____
11. **Since the onset of your current symptoms have you had:**
    Y/N Fever/Chills
    Y/N Unexplained weight change
    Y/N Dizziness or fainting
    Y/N Change in bowel or bladder functions
    Y/N Malaise (unexplained tiredness)
    Y/N Unexplained muscle weakness
    Y/N Night pain/sweats
    Y/N Numbness/ Tingling
    Other/describe_____
    _____
12. <u>Bladder/Bowel Habits/Problems</u>
    Y/N Trouble initiating urine stream
    Y/N Urinary intermittent/slow stream

Y/N Trouble emptying bladder
Y/N Difficulty stopping urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage

13. Do you have or have you had any of the following?

	Now	Past		Now	Past
Dizziness/ Vertigo			Diabetes		
Stroke			Arthritis		
Severe headaches			Osteoporosis		
Blurred Vision					
Double Vision			High blood pressure		
Ringing in your ears			Shortness of breath		
Nausea			Asthma		
Epilepsy			Chronic Bronchitis		
Multiple Sclerosis					
			Irregular heartbeat		
			Chest Pain		
Depression			Heart disease		
Chemical Dependency			Heart Attack		
Fever			Pacemaker		
Confusion			Congestive Heart Failure		
Pain in Calves			Peripheral Vascular Disease		
Muscle Pain			Thrombophlebitis		
Fatigue			Anemia		
Skin Disorder			Hemophilia		
Smoker How many Packs a day?_____			Cancer Please list type _____		
			Thyroid problems		
Tuberculosis			Kidney/ Bladder Problems		
Hepatitis C			Liver Problems		
Acquired Immune Deficiency/ HIV			Abdominal pain/discomfort		
Hepatitis B			Ulcer/ Colitis		
			Hernia		

14.If your family has a history of any of the above please list:

_____

_____

_____

15. List any other information regarding your medical history not detailed above:

_____

_____

_____

_____

16. Have you fallen in the past 2 years? If so, how many times and approximately when did the fall(s) occur?

_____

_____

Pelvic Symptom Questionnaire

Bladder/ Bowel Habits/ Problems

Y/N Trouble initiating urine stream
Y/N Urinary Intermittent/ slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current Laxative use
Y/N Trouble feeling bowl/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/ feces
Y/N Recurrent bladder infections
Other/describe_____

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____ times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?____ minutes, _____ hours, _____ not at all.
3. The usual amount of urine passed is: ___ small, ___ medium, ___ large.
4. Frequency of bowel movements _____ times per day, _____ times per week, Or _____.
5. 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.
6. If constipation is present describe management techniques
   _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day. Of this total how many glasses are caffeinated? _____ glasses per day.
8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/ pressure:
   ____None present
   ____Times per month (specify if related to activity or your period)
   ____With standing for_____ minutes or_____ hours.
   ____With exertion or straining
   ____Other

Skip questions if no leakage/incontinence

9. Bladder leakage – number of episodes
   ____No leakage
   ____Times per day
   ____Times per week
   ____Times per month
   ____Only with physical exertion/cough

   Bowel leakage – number of episodes
   ____No leakage
   ____Times per day
   ____Times per week
   ____Times per month
   ____Only with exertion/strong urge
10. On average, how much urine do you leak?
    ____No leakage
    ____Just a few drops
    ____Wets underwear
    ____Wets outerwear
    ____Wets the floor

    How much stool do you lose?
    ____No leakage
    ____Stool staining
    ____Small amount in underwear
    ____Complete emptying
11. What form of protection do you wear? (Please complete only one)
    ____None
    ____Minimal protection (Tissue paper/paper towel/pantishields)
    ____Moderate protection (absorbent product, maxipad)
    ____Maximum protection (Specialty product/diaper)
    ____Other_____

On average, how many pads/protection changes are required in 24 hours? _____# of pads

**I certify that the information I have provided is complete and true to the best of my knowledge.

I understand that I am financially responsible for all charges at the time services are rendered. I further understand that *ABove Physical Therapy*, LLC will provide me with the appropriate documentation to seek re-imbursement from my insurance provider. I acknowledge that *ABove Physical Therapy* is not responsible for the re-imbursement of these services.

I have read the foregoing and I understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

_____ Patient or Patient Representative Signature

_____ Witness

_____ Date

_____ Date