Wallace Physical Therapy

(Registration Form)

Patient Name: _____ Responsible Party: _____

Mailing Address: _____ City, State, Zip: _____

Perm Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: _____ D.O.B: _____ Age: _____ Patient SS#: _____

Responsible Party SS#: _____ Relationship to patient: _____

Emergency Contact Name: _____ Address: _____

Emergency Phone: _____ Injured on the job: _____

Personal Injury: _____ Attorney: _____

Phone/Address: _____ Patient E-mail Address:

_____

Primary Insurance

Co. Name: _____

Policyholder's Name: _____

Rel. to Patient: _____

Sex: _____ D.O.B: _____

ID #: _____

Group #: _____

Secondary Insurance

Co. Name: _____

Policyholder's Name: _____

Rel. to Patient: _____

Sex: _____ D.O.B: _____

ID#: _____

Group #: _____

Authorization to release information: I hereby authorize the release of any medical information necessary to process my claims. In the event that a dispute arises regarding non-payment for services between my doctor and my insurance company, I give my permission for the AZ department of Insurance to access my medical records if necessary to resolve the matter. I also authorize my insurance benefits be paid to Robert Wallace Physical Therapy. I understand that I am financially responsible for non- covered services.

I have been notified, if I miss an appointment without giving a 24 hour notice to WPT, I will be billed a $25.00 fee.

Signed: _____ Date: _____

Wallace Physical Therapy Billing Procedure
Billing Service Is: Assurance Medical Management
Account Manager Is: Bambi Anaya Contact Her At 318-3500 if you have any questions or concerns.

All other insurance patients:

You must first meet calendar year deductible before your insurance company will pay. Your claim will be filed to your insurance. Your insurance has 45 days to pay the claim unless they are asking for medical review. If your insurance is requesting further information from you please contact the billing service listed above and let them know. If you reach maximum benefits for physical therapy, the remaining balance is your responsibility and you will receive a statement. If you have a secondary, they will be billed when the primary pays. If you do not have a secondary, you will receive the bill for the remainder.

Self Pay Patients:

Payment is due at the time of service unless you have a signed agreement with Mr. Robert Wallace.

Workers Compensation Patients:

We need all employer information, the claim number, date of injury, and insurance company information. If we have received incomplete information, or if the insurance company denies the claim, you will be responsible for the bill. We will keep your employer and employer's insurance informed on your treatment and attendance.

Also when billing your medical insurance, we are given a quote of benefits not a guarantee of coverage. This will ultimately leave you responsible for the bill if your medical insurance does not pay.

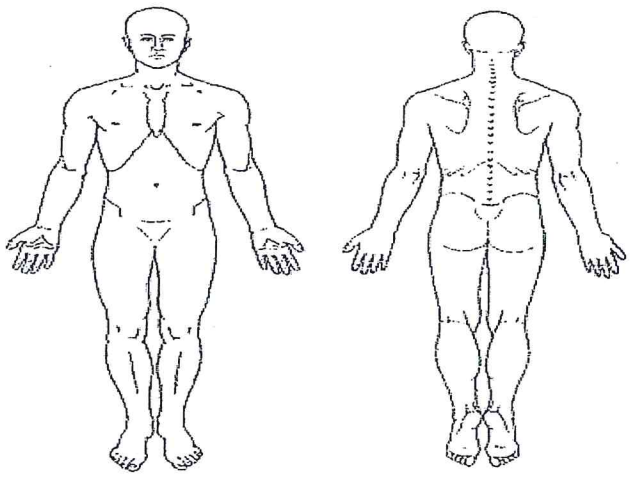
Statements are sent throughout your duration of therapy the balance will change as your insurance company pays. Just because you receive a statement does not mean that is all you owe. The numbers of statements depends on the length of therapy. Statements are sent once a month. When you have received 3 statements and no payments have been received, you will receive a final notice. You have 10 days to respond to the final notice; you may set up payment arrangements. If you do not respond, you will be going to collections. If you set up a payment plan, you need to make the promised payments; if you cannot, please contact the billing service. Once you are in collections it is your responsibility to get in contact with billing service when you receive your final notice.

Signature: _____ Date: _____

Pain / Problem Assessment

Name: _____ Date: _____

Please indicate areas where you have pain or problems for which we will be treating you:



Nature of your pain problem? (i.e. sharp, shooting, dull, aching, throbbing, etc.)

_____

_____

_____

Severity of pain – on a scale of 0-10 with 0 being no pain and 10 being severe pain.

Rank Pain at its WORST _____ 0 no pain

BEST _____ 1-2 very little

AVERAGE _____ 3-4 mild

5-6 moderate

7-8 a lot

9-10 excruciating

PAIN IS BEST WHEN I:

Sit_____ Lie Down _____ stand _____ walk _____ other _____

PAIN IS WORST WHEN I:

Sit _____ Lie Down _____ stand _____ walk _____ other _____

How is the pain problem affecting your life? (i.e. hurts to walk etc.)

_____

_____

_____

Signature: _____

Wallace Physical Therapy

ORTHOPEDIC-INDUSTRIAL-SPORTS-PERSONAL INJURY

MEDICAL HISTORY

Nombre: Fecha
NAME: _____ DATE: _____

Medico De Attencion Primaria
Primary Care Physician: _____

Medico De Referencia
Referring Physician: _____

Have you had surgeries for this injury: Y N
Type of Surgery: _____
Dates(s) of surgery (ies) for this injury:_____

Please list medications you're currently taking: _____
_____

Have you had any of the following intervention for this injury?

Urgent Care____
X-rays ____
CT Scan ____
MRI ____
EMG ____
OTHER ____

Chiropractor _____
Physical Therapy _____
Occupational Therapy _____
Orthopedist _____
Neurologist _____

Do you have or have you ever been treated for any of the following conditions:

Anemia_____
Allergies____
Arthritis____
Asthma____
Back Injury____
Blood Clots____
Cancer_____
Diabetes_____
Dizziness_____
Epilepsy_____
Headaches_____
Heart Disease_____

Hernia____
High Blood Pressure_____
Joint Replacement_____
Neck Pain _____
Numbness_____
Osteoporosis_____
Sleeping Disorder_____
Vision Problems_____
Weakness_____
Weight Loss_____
Are you pregnant? _____
Do you smoke? _____

Other: _____
I have reviewed the patient's medical history with him/her.

Therapist Signature: _____

Who may we thank for referring you to us? _____

INFORMED CONSENT for ASSESSMENT AND TREATMENT OF THE PELVIC FLOOR

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. I understand that it may be beneficial for my therapist to perform soft tissue assessment and treatment of the pelvic floor. Palpation of this area is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain, urinary or fecal incontinence, difficulty with bowel, bladder, or sexual functions, dyspareunia (pain with intercourse), pain from episiotomy or scarring, vulvodynia, vestibulitis, or other similar conditions. Restrictions in this area may also be contributing to symptoms in other areas of your body.

This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for biofeedback. I understand that the benefits of this procedure will be explained to me. I understand that, if I am uncomfortable with this treatment procedure AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

Treatment may include, but not be 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.

This direct pelvic floor release procedure utilizes myofascial release principles entailing the relaxation and lengthening of muscles, fascia and other soft tissue structures within the areas of the pelvic floor, sacrum, coccyx, and the sacroiliac, hip and pubic joints. The procedure also requires pressure and/or distraction directly to the coccyx bone. This technique is an accepted physical therapy technique, as indicated above. Our experience has demonstrated that this direct pelvic floor release is helpful, often facilitating consistent therapeutic results. As with any area of the body, most people require a series of these specific treatments. This is determined by your evaluation and treatment findings.

I have read and understand fully and consent to the above procedure being performed by the therapists at the Outpatient Therapy Dept.

Patient's Printed Name_____ Date_____

Patient's Signature_____

Witness 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 this procedure.

WALLACE PHYSICAL
5501 North Oracle Road, Suite 101
Tucson, Arizona 85704
Phone: 520-408-9547
Fax: 520-408-8145
www.wallacept.com

Pelvic Floor Therapy Questionnaire

Patient name: _____ Date: _____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at the appointment.

History

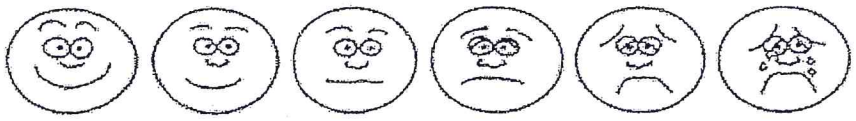
Number of pregnancies _____ Number of vaginal deliveries _____
Birth weight of largest baby _____ Number of cesarean deliveries _____
Number of episiotomies _____ Date of last pap smear _____

Did you have any trouble healing after delivery?	Y	N
Do you have a history of sexual abuse or trauma?	Y	N
Are you having regular periods/menstrual cycles?	Y	N
Do you have frequent urinary tract infections?	Y	N

Pain

Do you have pain with:

Sexual intercourse	Y	N
Pelvic exam	Y	N
Tampon use	Y	N
Back, leg, groin, abdominal pain	Y	N



0 NO HURT · 2 HURTS LITTLE BIT · 4 HURTS LITTLE MORE · 6 HURTS EVEN MORE · 8 HURTS WHOLE LOT · 10 HURTS WORST

Test Results

Urodynamic tests	Y	N	Results:
Cystoscope	Y	N	Results: _____
Urine test	Y	N	Results:
Bowel test	Y	N	Results: _____

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Bladder Symptoms

Do you lose urine when you:

Cough / sneeze / laugh	Y	N
Lift / exercise / dance / jump	Y	N
On the way to the bathroom	Y	N
Hear running water	Y	N
Have a strong urge to urinate	Y	N
Other _____	Y	N

Do you:

Wet the bed	Y	N
Have a burning / pain with urination	Y	N
Have difficulty starting a stream of urine	Y	N
Strain to empty your bladder	Y	N
Feel unable to empty the bladder fully	Y	N
Have a falling out feeling	Y	N
Have pain with a full bladder	Y	N
Have a strong urge to urinate	Y	N
Urinate more then 7 times per day	Y	N

Bowel Symptoms

Do you:

Strain to have a bowel movement	Y	N
Leak / stain feces	Y	N
Include fiber in your diet	Y	N
Have diarrhea often	Y	N
Take laxatives / enema regularly	Y	N
Leak gas by accident	Y	N
Have pain with a bowel movement	Y	N
Have a very strong urge to move your bowels	Y	N

How often do you move your bowels: _____ times per day / week

Most common stool consistency

_____ liquid _____ soft _____ firm _____ pellets _____ other_____

**Thank you for taking the time to fill out this questionnaire!

WALLACE

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Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel.

Today's Date: _____

		0	1	2	3	4
1	How many times do you go to the bathroom during the day?	3 to 6	7 to 10	11 to 14	15 to 19	20+
2	a. How many times do you go to the bathroom at night?	0	1	2	3	4+
	b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe	
3	Are you currently sexually active?	Yes	No			
4	a. **IF YOU ARE SEXUALLY ACTIVE,** do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always	
	b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always	
5	Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always	
6	Do you have urgency after going to the bathrrom?	Never	Occasionally	Usually	Always	
7	a. If you have pain, is it usually...		Mild	Moderate	Severe	
	b. Does your pain bother you?	Never	Occasionally	Usually	Always	
8	a. If you have urgency, is it usually...		Mild	Moderate	Severe	
	b. Does your urgency bother you?	Never	Occasionally	Usually	Always	

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Pelvic Floor Distress Inventory Short Form 20

POPDI-6	Please circle the answer that best fits you					
1) Usually experience pressure in the lower abdomen?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
2) Usual experience heaviness or dullness in the pelvic area?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
3) Usually have a bulge or something falling out that you can see or feel in your vaginal area?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
4) Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
5) usually experience a feeling of incomplete bladder emptying?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
6) Ever have to push up on a bulge in the vagina with your fingers to start or complete urination?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit

CRADI-8						
1) Feel you need to strain too hard to have a bowel movement?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
2) Feel you have no completely emptied your bowels at the end of a bowel movement?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
3) usually lose stool beyond your control, and your stool is well formed?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
4) Usually lose stool beyond your control, and your stool is loose?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
5) Usually lose gas from the rectum beyond your control?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
6) Usually have pain when you pass your stool?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
7) Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
8) Does part of your bowel ever pass through the rectum and bulge outside of the body either during or after a bowel movement?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit

UDI-6						
1) Usually experience frequent urination?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
2) Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation or needing to go to the bathroom?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
3) usually experience urine leakage related to cough, sneeze or laugh?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
4) Usually experience small amounts of urine leakage (that is, drops)?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
5) Usually experience difficulty emptying you bladder?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit
6) Usually experience pain or discomfort in the lower abdomen or genital region?	No	Yes	Not at all	Somewhat	Moderately	Quite a bit

Urogenital Distress Inventory

Instructions

Do you experience, and if so, how much are you bothered by:

Frequent Urination?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

Night time Urination?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

Urine leakage related to the feeling of urgency?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

Urine leakage related to physical activity, coughing or sneezing?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

General urine leak not related to urgency or activity?

- No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

Small amounts of urine leakage (drops)?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

Large amounts of urine leakage?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

Difficulty emptying your bladder?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

Pain or discomfort in the lower abdominal or genital area?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly