PATIENT REGISTRATION / INFORMATION SHEET

Pelvic Health Program

Name: _____
LAST FIRST MIDDLE

Date of Birth: _____ Gender (at birth): ☐ Male ☐ Female Marital Status: _____

Email Address: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Primary Language: _____

Religious Preference: _____

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ White ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ On Active Military Duty ☐ Retired
☐ Disabled ☐ Self Employed ☐ Student Full-Time ☐ Student Part-Time

Employer: _____ Occupation: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance: ☐ HMO ☐ POS/PPO ☐ Medicare ☐ Cash ☐ Other: _____

Insurance Company Name: _____

Group Number: _____ Policy/ID Number: _____

Secondary Insurance: ☐ HMO ☐ POS/PPO ☐ Medicare ☐ Cash ☐ N/A ☐ Other: _____

Insurance Company Name: _____

Group Number: _____ Policy/ID Number: _____

Primary Subscriber Name: _____
LAST FIRST MIDDLE

Relationship: _____ Date of Birth: _____ Gender: ☐ M ☐ F

Street Address: _____ City: _____ State: _____ Zip: _____

Employment Status: _____ Employer: _____

Primary Care Physician: _____ Phone Number: _____

[2052]

PATIENT LABEL

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For what reason are you seeking treatment? (Check all that apply)

BLADDER SYMPTONS:

- ☐ urinary incontinence (problem with bladder control)
- ☐ urinary urgency (rushing to the toilet)
- ☐ urinary frequency (too frequent voiding)
- ☐ problem with bladder emptying (feeling incomplete bladder emptying after urinating)
- ☐ pain with bladder emptying
- ☐ other (please describe): _____

BOWEL SYMPTOMS:

- ☐ fecal incontinence (problem with bowel control)
- ☐ problem with bowel urgency (rushing to toilet)
- ☐ problem with bowel emptying (feeling of incomplete bowel emptying after a bowel movement)
- ☐ pain with bowel emptying
- ☐ other (please describe): _____

For those with a vagina:

- ☐ pelvic prolapse (bulge or protrusion in the vagina)
- ☐ pain with vaginal penetration
- ☐ pelvic pain (please describe WHERE you have pain): _____

For those with testicles:

- ☐ pain with erection
- ☐ pain with ejaculation
- ☐ pelvic pain (please describe WHERE you have pain): _____

PAIN

If you have pain related to why you are here, please indicate how much pain you experience on the scale below where 0= no pain and 10=most severe pain:

Pain Level	0	1	2	3	4	5	6	7	8	9	10
Pain at Best	0	1	2	3	4	5	6	7	8	9	10
Pain at Worst	0	1	2	3	4	5	6	7	8	9	10

Please describe the pain (location, when it started and why, description, frequency):

_____

_____

What makes your pain worse? _____

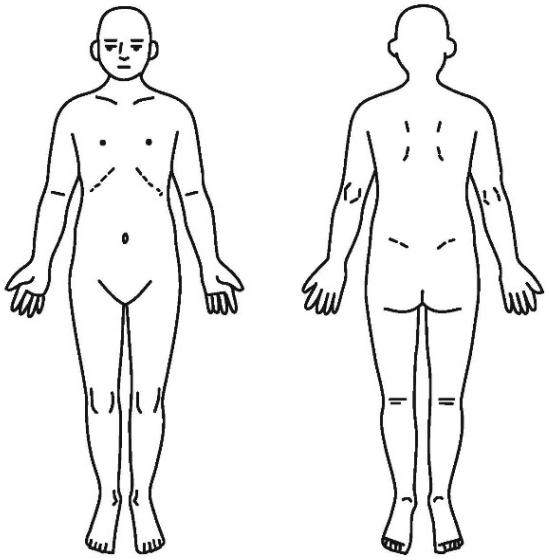
What makes your pain better? _____

What treatments have you tried or what have you done to improve your symptoms? _____

_____

PATIENT LABEL

PLEASE USE AN "X" TO INDICATE YOUR PAIN ON THE FIGURE:



OBSTETRIC HISTORY (if applicable)

Are you pregnant? ☐ Yes ☐ No
If yes, how many weeks pregnant? _____ When is your due date? _____
How many pregnancies have you had? _____
How many children have you given birth to? _____ ☐ vaginal ☐ cesarean section
Did you have any of the following (please check all that apply):
☐ perineal tear ☐ vacuum delivery
☐ forceps ☐ baby weighing 8 pounds or more
☐ episiotomy ☐ other:_____

MENSTRUAL HISTORY (if applicable)

Period cycle (days)? _____ Period duration (days)? _____
Period pattern: ☐ Regular ☐ Irregular
Menstrual flow: ☐ Light ☐ Moderate ☐ Heavy
Menstrual control: ☐ Panty liner ☐ Thin pad ☐ Medium pad ☐ Maxi pad ☐ Tampon ☐ Menstrual cup ☐ Other
Menstrual control change frequency: _____
Dysmenorrhea (pain with periods): ☐ None ☐ Mild ☐ Moderate ☐ Severe
Type of birth control used (if applicable)? _____
Have you gone through menopause? ☐ Yes ☐ No

HORMONE THERAPY (if applicable)

Are you using any hormones? ☐ Yes ☐ No
If Yes: ☐ Estrogen ☐ Progesterone ☐ Testosterone ☐ Other, please describe: _____

BLADDER HABITS & SYMPTOMS

Urine Stream: ☐ normal ☐ weak ☐ intermittent ☐ difficult to initiate
Bladder emptying: ☐ complete ☐ incomplete ☐ strain to empty ☐ leak immediately after urinating
Frequency of bladder urgency: ☐ never ☐ occasionally ☐ frequently ☐ always
Urinary urge sensation: ☐ normal ☐ strong ☐ sudden ☐ none ☐ other
Daytime frequency of urination: _____ Nighttime frequency of urination: _____
Just in case urination habit: ☐ Yes ☐ No
Do you get frequent bladder infections? ☐ Yes ☐ No

PATIENT LABEL

URINE LEAKAGE (if you have unintentional loss of urine, please answer the following questions)

Amount: ☐ none ☐ few drops ☐ small amount ☐ medium amount ☐ large amount

Leakage protection: ☐ none ☐ panty liner ☐ pads ☐ absorbent underwear ☐ other

Number of pads used for urine loss per day: _____

Leakage after leaving the toilet: ☐ Yes ☐ No

Are you able to stop your urine flow intentionally? ☐ Yes ☐ No ☐ Never tried

ICIQ:

How often do you leak?

☐ never (0) ☐ about once a week or less (1) ☐ two or three times a week (2)

☐ about once a day (3) ☐ several times a day (4) ☐ all the time (5)

We would like to know how much urine you think leaks?

☐ none (0) ☐ a small amount (2)

☐ a moderate amount (4) ☐ a large amount (6)

Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal).

0 1 2 3 4 5 6 7 8 9 10

Activities associated with urine loss (check all that apply):

☐ coughing ☐ bending ☐ sneezing ☐ lifting

☐ laughing ☐ sleeping ☐ walking ☐ anxiety/stress

☐ jumping ☐ sexual activity/climax ☐ exercise ☐ with a strong urge to urinate

☐ sit to stand ☐ on the way to the toilet

BOWEL SYMPTOMS (if applicable)

Stool Consistency (soft, hard, or Bristol stool scale #): _____

Frequency of bowel movements:

☐ less than 3 times per week ☐ 3-5 times per week ☐ 1 time per day ☐ 2-3 times per day ☐ more than 3 times per day

Frequency of bowel urgency:	☐ never	☐ occasionally	☐ frequently	☐ always
Straining/Pushing:	☐ never	☐ occasionally	☐ frequently	☐ always
Feeling of incomplete emptying:	☐ never	☐ occasionally	☐ frequently	☐ always
Abdominal fullness/ bloating:	☐ never	☐ occasionally	☐ frequently	☐ always
Pain with bowel movements:	☐ never	☐ occasionally	☐ frequently	☐ always
Manual assistance with bowel movements:	☐ never	☐ occasionally	☐ frequently	☐ always
Constipation:	☐ never	☐ occasionally	☐ frequently	☐ always
Hemorrhoids:	☐ absent	☐ history of	☐ present	
Bowel incontinence:	☐ none	☐ liquid stool	☐ solid stool	☐ flatulence ☐ other
Amount of fecal leakage:	☐ small	☐ medium	☐ large	

Do you take any fiber supplements, laxatives, or stool softeners? ☐ Yes ☐ No

If yes, please list: _____

PATIENT LABEL

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BOWEL LEAKAGE (if you have unintentional loss of stool, please answer the following questions)

Bowel incontinence: ☐ none ☐ liquid stool ☐ solid stool ☐ flatulence ☐ other

Frequency of Fecal Leakage: ☐ multiple times per month ☐ weekly ☐ multiple times per week ☐ daily ☐ multiple times per day ☐ constant

Amount of fecal leakage: ☐ smearing ☐ small ☐ medium ☐ large

Leakage protection: ☐ none ☐ pads ☐ liners ☐ other

SEXUAL SYMPTOMS

Are you sexually active? ☐ Yes ☐ No With: ☐ men ☐ women ☐ both

Do you have any sexually transmitted diseases? ☐ Yes ☐ No If yes, please list: _____

Do you experience any pain or discomfort with sexual activity? ☐ Yes ☐ No

Are you able to achieve an erection? ☐ Yes ☐ No ☐ Partial

What is your current activity level?

☐ sedentary ☐ light ☐ moderate ☐ heavy

What do you do for exercise/ fitness and how often do you do this?

_____

_____

WHAT ARE YOUR GOALS FOR TREATMENT?

Please identify ONE ACTIVITY that is difficult or that you are unable to perform due to the condition you are seeking treatment for and rate that difficulty on the scale below:

Activity: _____

0 1 2 3 4 5 6 7 8 9 10

Unable to perform Performs easily

Is there anything else you would like to add?

_____

_____

Please list ALL of your medications:

Medication	Dose	Frequency	Medication	Dose	Frequency

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Please check any of the following medical conditions that you have or have had:

- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer/type:_____
- ☐ Carpal tunnel
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Fractures/type:_____
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Multiple sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ehlers Danlos Syndrome (EDS)
- ☐ Mast Cell Activation Syndrome (MCAS)
- ☐ Other: _____

History of depression or anxiety? ☐ Yes ☐ No
If yes, have you found successful treatments? Please explain: _____

Over the last 2 weeks, how often have you been bothered by the following problems?
Little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half the days ☐ nearly every day
Feeling down, depressed, or hopeless? ☐ Not at all ☐ Several days ☐ More than half the days ☐ nearly every day

Have you had any back, hip, or pelvic injuries? ☐ Yes ☐ No
If yes, please describe: _____

Please list ALL surgeries and the dates they were performed:

_____

_____

Do you have an implanted device (Interstim, IUD, pacemaker)? _____

Please indicate whether you have had any special tests or procedures (with dates) for your bladder or bowel:

_____

Do you have any drug allergies? ☐ Yes ☐ No
If yes, what are they? _____

_____

Do you have any other allergies? (latex, tape, iodine/contrast) ☐ Yes ☐ No
If yes, what are they?_____

Have you fallen in the last year? ☐ Yes ☐ No
If yes, how many times? _____

Because violence in the home is a serious health risk, we ask everyone:
Have you ever been forced to engage in sexual activity against your will? ☐ Yes ☐ No

Patient/Legal Representative Signature: _____ Date: _____ Time: _____A.M./P.M.

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

Reviewed by: _____ Date: _____ Time: _____A.M./P.M.

PATIENT LABEL

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FINANCIAL POLICY

I understand and agree, regardless of my insurance status, that I am ultimately responsible for the payment of all services provided to me by Hoag Pelvic Health Program. All financial arrangements made, including copays, apply solely to the dates of service covered by my insurance company. Should my insurance deny payment or portion of payment for any reason, all charges will be my financial responsibility. I hereby authorize my insurance benefits of any kind to be paid directly to Hoag Pelvic Health Program. I further authorize Hoag Pelvic Health Program to release any medical records or information to any insurance company as necessary or required to process my insurance claims. In the event that it is necessary for Hoag Pelvic Health Program to refer your unpaid account to an attorney for legal action, including the filing of a claim for monetary damages, and should Hoag Pelvic Health Program be successful in obtaining a judgement against you, then you agree to pay in addition to the balance due, all applicable charges, attorney's fees and costs that the court may access against you. *I CERTIFY THAT I HAVE READ THIS DOCUMENT IN IT'S ENTIRETY AND AGREE TO THE TERMS & CONDITIONS WITHIN. I AGREE THAT THE ABOVE INFORMATION IS CORRECT AND TO THE PLAN OF CARE SET FORTH TO ME BY MY PHYSICAL THERAPIST.*

Initial here: _____

CANCELLATION POLICY

As our patient, we value you and your time and ask that you do the same. In order to best serve our patients, we ask that all cancellations be made 48 hours prior to your appointment time. Adherence to this policy allows us to coordinate care for another patient needing care. Should you miss 2 consecutive visits in a row without communication with our front office, your remaining visits will be cancelled, and given to other patients in need of treatment. You will have the opportunity to get back on your physical therapist's schedule by contacting the front office at your earliest convenience. *I HAVE READ THE Hoag Pelvic Health Program CANCELLATION POLICY ABOVE & AGREE TO ABIDE BY ITS TERMS.*

Initial here: _____

APPOINTMENT REMINDER NOTIFICATION PREFERENCES

You give us permission to provide appointment reminders by phone, email or text.

I AUTHORIZE EMPLOYEES FROM HOAG PELVIC HEALTH PROGRAM TO LEAVE ME A VOICEMAIL WITH PROTECTED HEALTH INFORMATION. Initial here: _____

I AUTHORIZE EMPLOYEES FROM HOAG PELVIC HEALTH PROGRAM TO SEND ME EMAILS WITH PROTECTED HEALTH INFORMATION. Initial here: _____

HOAG PELVIC HEALTH PROGRAM EMPLOYEES MAY LEAVE A VOICEMAIL WITH PROTECTED HEALTH INFORMATION TO THE FOLLOWING NUMBER: _____

Patient/Legal Representative Signature: _____ Date: _____ Time: _____A.M./P.M.

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

PATIENT LABEL

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NOTICE OF PRIVACY PRACTICES

TO OUR PATIENTS, THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF HOAG PELVIC HEALTH PROGRAM) MAY BE USED & DISCLOSED, & HOW YOU CAN OBTAIN ACCESS TO YOUR HEALTH INFORMATION. THIS IS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA). HOAG PELVIC HEALTH PROGRAM IS DEDICATED TO MAINTAINING. THE PRIVACY OF YOUR HEALTH INFORMATION. WE ARE REQUIRED BY LAW TO MAINTAIN THE CONFIDENTIALITY OF YOUR HEALTH NFORMATION. WE REALIZE THAT THESE LAWS ARE COMLICATED, BUT WE MUST PROVIDE YOU WITH THE FOLLOWING IMPORTANT INFORMATION:

THE FOLLOWING CIRCUMSTANCES MAY REQUIRE US TO USE OR DISCLOSE YOUR HEALTH INFORMATION:

1. TO PUBLIC HEALTH AUTHORITIES & HEALTH OVERSIGHT AGENCIES THAT ARE AUTHORIZED BY LAW TO COLLECT INFO.

2. LAWSUITS AND SIMILAR PROCEEDINGS IN RESPONSE TO A COURT OR ADMINSTRATIVE ORDER.

3. IF REQUIRED TO DO SO BY A LAW ENFORCEMENT OFFICIAL.

4. WHEN NECESSARY TO REDUCE OR PREVENT A SERIOUS THREAT TO THE HEALTH & SAFETY OF ANOTHER INDIVIDUAL OR THE PUBLIC. THESE DISCLOSURES WILL ONLY BE MADE WITH PERSONS OR ORGANIZATIONS WHO ARE ABLE TO HELP PREVENT SUCH A THREAT.

5. IF YOU ARE A MEMBER OF U.S. OR FOREIGN MILITARY (INCLUDING VETERANS) AND IF REQUIRED BY THE APPROPRIATE AUTHORITIES.

6. TO FEDERAL OFFICIALS FOR INTELLIGENCE AND NATIONAL SECURITY ACTIVITIES AUTHORIZED BY LAW.

7. TO CORRECTIONAL INSTITUTIONS OR LAW ENFORCEMENT OFFICIALS IF YOU ARE AN INMATE/UNDER THE CUSTODY OF A LAW ENFORCEMENT OFFICIAL.

8. FOR WORKERS COMPENSATION AND SIMILAR PROGRAMS.

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YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. COMMUNICATIONS: YOU CAN REQUEST THAT HOAG PELVIC HEALTH PROGRAM COMMUNICATE WITH YOU ABOUT YOUR HEALTH & RELATED ISSUES IN A PARTICULAR MANNER OR AT A CERTAIN LOCATION. FOR INSTANCE, YOU MAY ASK THAT WE CONTACT YOU AT HOME RATHER THAN WORK. WE WILL ACCOMMODATE ALL REASONABLE REQUESTS.
2. YOU CAN REQUEST A RESTRICTION IN OUR USE OR DISCLOSURE OF YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. ADDITIONALLY, YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRCIT DICLOSURE OF YOUR HEALTH INFORMATION TO ONLY CERTAIN INDIVIDUALS INVOLDED IN YOUR CARE OR THE PAYMENT FOR YOUR CARE, SUCH AS FAMILY MEMBERS & FRIENDS. WE ARE NOT REQUIRED BY LAW TO AGREE TO YOUR REQUEST; HOWEVER, IF WE DO AGREE WE ARE BOUND BY OUR AGREEMENT EXCEPT WHEN OTHERWISE REQUIRED BY LAW, IN EMERGENCIES, OR WHEN THE INFORMATION IS NECESSARY TO TREAT YOU.
3. YOU HAVE THE RIGHT TO INSPECT AND OBTAIN A COPY OF THE HEALTH INFORMATION THAT MAY BE USED TO MAKE DECISIONS ABOUT YOU, INCLUDING PATIENT & MEDICAL RECORDS AND BILLING RECORDS, BUT NOT INCLUDING PSYCHOTHERAPY NOTES. YOU MUST SUBMIT YOUR REQUEST IN WRITING TO HOAG PELVIC HEALTH PROGRAM OR CONTACT THE OFFICE FOR FURTHER INFORMATION.
4. YOU MAY ASK US TO AMEND YOUR HEALTH INFORMATION IF YOU BELIEVE IT IS INCORRECT OR INCOMPLETE, AND AS LONG AS THE INFORMATION IS KEPT BY OR FOR OUR PRACTICE. TO REQUEST AN AMENDMENT, YOUR REQUEST MUST BE MADE IN WRITING & SUBMITTED TO HOAG PELVIC HEALTH PROGRAM, OR CONTACT THE OFFICE FOR FURTHER INFORMATION. YOU MUST PROVIDE US WITH A REASON THAT SUPPORTS YOUR RQUEST FOR AMENDMENT.
5. RIGHT TO A COPY OF THIS NOTICE. YOU ARE ENTITLED TO RECEIVE A COPY OF THIS NOTICE OF PRIVACY PRACTICES. YOU MAY ASK US TO GIVE YOU A COPY OF THIS NOTICE AT ANY TIME. TO OBTAIN A COPY OF THIS NOTICE, CONTACT OUR OFFICE.
6. RIGHT TO FILE A COMPLAINT. IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH OUR PRACTICE OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. TO FILE A COMPLAINT WITH OUR PRACTICE, CONTACT THE OFFICE FOR FURTHER INFORMATION. ALL COMPLAINTS MUST BE SUBMITTED IN WRITING. YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.
7. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES. HOAG PELVIC HEALTH PROGRAM WILL OBTAIN YOUR WRITTEN AUTHORIZATION FOR USES AND DISCLOSURES THAT ARE NOT IDENTIFIED BY THIS NOTICE OR PERMITTED BY APPLICABLE LAW. IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OR OUR HEALTH INFORMATION PRIVACY POLICIES, PLEASE CONTACT HOAG PELVIC HEALTH PROGRAM. *I HEARBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF HOAG PELVIC HEALTH PROGRAM PRIVACY PRACTICES*

Patient/Legal Representative Signature: _____ Date: _____ Time: _____A.M./P.M.

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

PATIENT LABEL

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INFORMED CONSENT FOR PHYSICAL THERAPY

Physical therapy is the art and science of physical/corrective rehabilitation for a wide variety of conditions, diseases, or injuries. It includes examination, evaluation, diagnosis, prognosis, and interventions through the use of various treatment techniques including joint mobilizations, soft tissue mobilization and myofascial release, massage, therapeutic exercise, neuromuscular re-education, patient education, and modalities such as heat/ice, electrical stimulation, and ultrasound. Physical therapy practice also includes consultation, promotion, and maintenance of physical fitness, health, and wellness through physical therapy interventions and education.
Informed consent means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. Given each individuals presenting condition there is a variety of physical therapy services and interventions that may be included in your care and will be explained to you by your physical therapist during the initial evaluation.

Every individual responds differently to physical therapy interventions, and it is therefore difficult to predict your response to any one treatment technique or procedure. HOAG PELVIC HEALTH PROGRAM cannot guarantee that treatment will resolve or improve your condition or can guarantee that you won't have a negative reaction to treatment. Prior to your consent to treatment, your physical therapist will discuss their opinion on the potential results and anticipated outcomes given the various treatment techniques and procedures to be provided.

Potential benefits include but not limited to: Decrease in pain and symptoms, improvement in function, strength, flexibility, endurance, awareness, and greater knowledge and ability to manage presenting condition.

Potential risks may include: Increase or aggravation of pain or presenting symptoms, and may cause injury. Most aggravation or increased pain is temporary and can be discussed with your physical therapist.

You have the right to decline any part of treatment at any time for any reason. It is your right to ask your physical therapist questions regarding any part of your care and to discuss the potential risks and benefits specific to your treatment plan. It is your right to decline participating in the physical therapy program presented. Alternatives to physical therapy can be discussed including returning to your physician for other treatment options.

I have read and understand all of the information above and consent to physical therapy evaluation and treatment. I agree to fully cooperate, participate, and comply with the established plan of care.

Patient/Legal Representative Signature: _____ Date: _____ Time: _____A.M./P.M.

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

The undersigned certifies that he/she has read the conditions of patient care for Hoag's Pelvic Health Program, received a copy, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

PATIENT LABEL