PHYSICAL THERAPY
CHIROPRACTIC
ACUPUNCTURE
MASSAGE THERAPY

Pelvic Floor PT **New Patient Paperwork**

Name_____

Date _____

Patient Information

First Name_____ Middle Name_____ Last Name_____

Sex: Male Female Marital Status: Married Single Divorced DOB_____

Address: _____ _____ _____

City_____ State_____ Zip_____

Home #_____ Work #_____ Cell #_____

Email:_____ _____ Cell Provider_____

Emergency Contact_____ Relation_____ Phone_____

Spouse's Name_____ Parent Name (If patient is a minor)_____ _____

Employed: Full Part Unemployed Student:_____ School_____

Employer Name_____ Employer Address_____ _____

Occupation_____ Zip _____ _____

How did you hear about our office? Patient Referral Physician Referral Name_____

Insurance Information

Primary Ins_____ Phone #: _____ ID#_____

Group#_____

Claim Address: _____

City: _____ State: _____ Zip: _____

Subscriber Name_____ Subscriber DOB_____ Secondary ID_____

Secondary Ins_____ Secondary Phone #:_____ Secondary GRP_____

Secondary Address: _____

City: _____ State: _____ Zip_____

Subscriber Name_____ Subscriber DOB_____

18 Wyckoff Ave Suite 201 Waldwick, NJ 07463
Phone: 201-447-5757 Fax: 201-447-5750
Totalhealth@drstevejones.com

Name _____

Date _____

History Information

Last Physical Exam _____ OB/GYN Physician _____ Phone#_____

Height_____ Weight _____

General Health:	Excellent	Good	Average	Fair	Poor
Stress Level:	High	Medium	Low		
Surgery:	Yes	No	Explain _____		
Broken Bones:	Yes	No	Explain _____		
Sprains:	Yes	No	Explain _____		

Medications _____

Supplements _____

Pregnant:	Yes	No	Planning:	Yes	No
Vaginal Deliveries	Yes	No	Number _____		
Cesarian Sections	Yes	No	Number _____		
Episiotomy	Yes	No	Number _____		
Difficult Childbirth	Yes	No	Number _____		
Organ Prolapse	Yes	No	Explain _____		
Vaginal Dryness	Yes	No			
Painful Periods	Yes	No			
Painful Intercourse	Yes	No			
Pelvic Pain	Yes	No			
Menopause	Yes	No	When _____		

Other _____

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New Patient Paperwork

Name_____

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Health Checklist (Please check all that apply)

Allergies	Alcoholism	Anemia
Arteriosclerosis	Arthritis/Rheumatoid	Asthma
Back Pain	Breast Lump	Bronchitis
Bruise Easily	Cancer	Chest Pain
Cold Extremities	Constipation	Cramps
Depression	Diabetes	Digestion Problems
Dizziness	Excessive Menstruation	Eye Pain/Difficulties
Fatigue	Frequent Urination	Headache
Hemorrhoids	High Blood Pressure	Hot Flashes
Irregular Heartbeat	Irregular Menstrual Cycle	Kidney Infection
Kidney Stones	Loss of Memory	Loss of Balance
Loss of Smell	Loss of Taste	Nosebleeds
Pacemaker/Defibrillator	Polio	Poor Posture
Prostate	Sciatica	Shortness of Breath
High Blood Pressure	Sinus Infection	Insomnia
Spinal Curvatures	Stroke	Swelling of Ankles
Swollen Joints	Thyroid Condition	Tuberculosis
Ulcers	Varicose Veins	Heart Disease
Seizures	STDs	HIV
Hepatitis	Osteoporosis/Osteopenia	Multiple Sclerosis
Blood Clots	Latex Sensitivity	Parkinson's Disease
Pelvic Organ Prolapse	Urinary Incontinence	Pelvic Pain

Social Information

Alcohol:	Daily	Weekly	Occasionally	Never
Caffeine:	Daily	Weekly	Occasionally	Never
Drugs:	Daily	Weekly	Occasionally	Never
Tobacco:	Daily	Weekly	Occasionally	Never
Exercise:	Daily	Weekly	Occasionally	Never
Water:	Daily	Weekly	Occasionally	Never

Name _____

Date _____

Complaint Information

Is problem related to a specific incident: Yes No Date of incident _____

Please describe _____

Frequency of Pain: Always Hourly Daily Occasionally

Severity of Pain: 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the nature of the pain _____

Have you received treatment? Yes No Explain _____

_____

Are you able to work? Yes No Disability: Yes No

Activity restrictions? Yes No

Are you able to exercise? Yes No Frequency _____

Has your diet/fluid intake changed? Yes No Explain _____

Have your social activities changed? Yes No Explain _____

Activities/events that cause or aggravate your symptoms (Check all that apply)

___ Sitting greater than ___minutes	___ Coughing/Sneezing/Straining
___ Walking greater than_____minutes	___ Laughing/Yelling
___ Standing greater than____minutes	___ Lifting/Bending
___ Changing positions (sitting to standing)	___ Cold Weather
___ Light activity (light housework)	___ Triggers (running water/key in the door)
___ Vigorous activity (run/weight lifting/jumping	___ Nervousness/Anxiety
___ Sexual activity	___ No activities affect the problem
Other_____	_____

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Since the onset of your current symptoms have you had:

___ Fever	___ Chills
___ Unexplained weight changes	___ Unexplained muscle weakness
___ Dizziness or fainting	___ Night pain/sweats
___ Change in bladder/bowel functions	___ Numbness/Tingling

Bladder/Bowel Problems

___ Trouble initiating urine stream	___Urine leaking during exercise
___ Urinary intermittent/slow stream	___ Painful urination
___ Trouble emptying bladder	___ Trouble feeling bladder urge/fullness
___ Difficulty stopping urine stream	___ Current laxative use
___ Trouble emptying bladder completely	___ Trouble feeling bowel urge/fullness
___ Straining/pushing to empty bladder	___ Constipation/Straining
___ Dribbling after urination	___ Trouble holding back gas/feces
___ Constant urine leakage	___ Recurrent bladder infections

Frequency of urination: ___times per day ___times per night

When you have a normal urge to urinate how long can you hold it? ___minutes ___hours ___never

The usual amount of urine passed is: ___small ___medium ___large

Frequency of bowel movements: ___times per day ___times per night

When you have an urge to have a bowel movement how long can you hold it?

___ minutes ___hours ___never

Are you constipated? Yes No

Treatment for constipation _____

Average fluid intake: ___glasses per day

How many are caffeinated? ___glasses per day

Rate your feeling of organ prolapse or pelvic heaviness/pressure: ___None ___Times per month

Is feeling related to activity or your period? Yes No

Is feeling related to standing? ___Minutes ___Hours

Is feeling related to exertion/straining? Yes No

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Bladder Leakage (Number of Episodes)	Average amount of leakage (Check One)
___ No leakage	___ No leakage
___ Times per day	___ Just a few drops
___ Times per week	___ Wets underwear
___ Times per month	___ Wets outerwear
___ Only w/Physical exertion/cough	___ Wets the floor

Bowel Leakage (Number of Episodes)	Average amount of stool lost (Check One)
___ No Leakage	___ No leakage
___ Times per day	___ Stool staining
___ Times per week	___ Small amount in underwear
___ Times per month	___ Complete emptying
___ Only w/Physical exertion/cough	

What form of protection do you wear? (Please check only one)

___ None

___ Minimal protection (Tissue paper/paper towel/panty shield)

___ Moderate protection (Absorbent product/Maxipad)

___ Maximum protection (Specialty product/diaper)

___ Number of pad/protection changes required in 24 hours

Additional Comments

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Pelvic Floor Distress Inventory Questionnaire (If yes, circle one)

Do you usually experience pressure in the lower abdomen?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience heaviness or dullness in the lower abdomen?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually have a bulge or something falling out that you can see or fell in the vagina area?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience a feeling of incomplete bladder emptying?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you feel you need to strain too hard to have a bowel movement?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually lose stool beyond your control if your stool is well formed?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually lose stool beyond your control if your stool is loose or liquid?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually lose gas from the rectum beyond your control?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually have pain when you pass your stool?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience frequent urination?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience urine leakage related to laughing, coughing or sneezing?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience small amounts of urine leakage (that is, drops)?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience difficulty emptying your bladder?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience pain or discomfort in the lower abdomen or genital region?	Yes / No	Not at all	Somewhat	Moderately	Quite a bit

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Pelvic Floor Impact Questionnaire

How do symptoms/conditions usually affect your:	Bladder/Urine	Bowel/Rectum	Vagina
Ability to do household chores (cooking, laundry, housecleaning)?	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit
Ability to do physical activities such as walking, swimming or other exercise?	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit
Entertainment activities such as going to a movie or concert?	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit
Ability to travel by car or bus for a distance greater than 30 minutes away from home?	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit
Participating in social activities outside your home?	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit
Emotional health (nervousness, depression, etc)	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit
Feeling frustrated?	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit	o Not at all o Somewhat o Moderately o Quite a bit

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Name _____

Date _____

HIPAA PRIVACY POLICY

I understand that I have certain rights to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize TOTAL HEALTH ASSOCIATES to use and disclose my protected health information to carry out treatment, including direct or indirect treatment by other healthcare providers involved in my treatment, obtaining payment from third party payers and day to day healthcare operations of TOTAL HEALTH ASSOCIATES. I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that THA reserves the right to change the terms of this notice and that I may contact THA at any time to obtain an up-to-date copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, however, THA is under no obligation to comply with these requested restrictions. In the case that restrictions are mutually agreed upon THA is bound to comply with these new restrictions. I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Name of Patient or Legal Guardian _____

Signature of Patient or Legal Guardian _____

Date _____

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Name _____

Date _____

Financial Policies and Procedures

Total Health Associates is an out of network healthcare provider. Total Health Associates uses the out of network benefit information that has been provided to us by your insurance company. These benefit guidelines have been verified; however, they are not a guarantee of payment. In most cases, Total Health Associates will assist the patient in submitting claims and providing any documentation to facilitate the reimbursement process. In the case that your insurance carrier denies payment, you are personally responsible for all fees incurred at Total Health Associates.

I am responsible for understanding my insurance benefit information. I also understand that I am responsible for my account balance(s) in the case that my insurance provider denies payment.

Signature _____ Date _____

If you are a Blue Cross Blue Shield member, provider reimbursement checks will be made out and mailed directly to you. Please remit these checks to our office for payment of services within 14 days of receipt. Total Health Associates will keep a credit card on file to be used in the case that insurance checks are not submitted to the office for payment.

I authorize Total Health Associates to charge my credit card for services in the case that paid-to-patient insurance checks are not submitted to the office for reimbursement.

Our office required 24 hours' notice for any cancelations. I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance or if I do not show for an appointment, I will pay a cancellation/no show fee of $75 for one-on-one physical therapy treatments.

Patient name: _____

Credit Card # _____ CVV _____ Exp. _____

Signature: _____ Zip code _____

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Name _____

Date _____

Conditions and Informed Consent for Pelvic Floor Physical Therapy

I understand that I am a patient of Jennifer Collard, PT who is an independent Physical Therapy practitioner at Total Health Associates, LLC. My care is the exclusive responsibility of Jennifer Collard, PT, not of any other practitioners who also may practice at this location.

In order for Physical Therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $75.

I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist. I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience decreased pain and discomfort. If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternative with my physician or primary care provider.

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to TOTAL HEALTH ASSOCIATES. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctors and licensed providers to release all information necessary to any insurance company, attorney or adjustor for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me and I am responsible for timely payment of such services. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and an individual. I understand that fees for professional services are due at the time of service.

Name of Patient or Legal Guardian _____

Signature of Patient or Legal Guardian _____

Date _____

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