PHYSICAL THERAPY
CHIROPRACTIC
ACUPUNCTURE
MASSAGE THERAPY

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 Code:_____

Home #:_____ Work #:_____ Cell #:_____

Email:_____ Cell Provider:_____

Emergency Contact:_____ Relation:_____ Phone:_____

Spouse's Name:_____ Parent's Name (If patient is aminor):_____

Employed: Full Part Unemployed Student:_____ School:_____

Employer Name:_____ Employer Address:_____

Occupation:_____ How did you hear about our office? Name: _____

Insurance Information

Primary Ins:_____ Phone #:_____ ID#:_____

Claim Address:_____ Group#_____

_____

City: _____ State: _____ Zip Code:_____

Subscriber Name_____ Subscriber DOB:_____ Secondary ID#:_____

Secondary Ins_____ Secondary Phone #:_____ Secondary GRP#:_____

Secondary Address: _____

City: _____ State: _____ Zip Code:_____

Subscriber Name_____ Subscriber DOB:_____

Name _____

Date _____

Complaint Information

How did injury occur? ☐ Auto Accident ☐ Work ☐ School ☐ Sports ☐ Other

Date of injury _____

Describe discomfort _____

Frequency of pain: ☐ Always ☐ Hourly ☐ Daily ☐ Occasionally

Does pain interfere with activities _____ Pain interfere with sleep? _____

Are you able to work? ☐ Yes ☐ No Explain _____

Have you received treatment? ☐ Yes ☐ No Explain _____

Xrays? ☐ Yes ☐ No Date _____

MRI? ☐ Yes ☐ No Date _____

History Information

Last physical exam _____ Primary Care Physician _____ Phone# _____

Height _____ Weight _____

Previous Chiropractic: ☐ Yes ☐ No Explain: _____

Previous PT: ☐ Yes ☐ No Explain: _____

Previous Acupuncture: ☐ Yes ☐ No Explain: _____

Previous Massage: ☐ Yes ☐ No Explain: _____

Pregnant: ☐ Yes ☐ No Planning: ☐ Yes ☐ No

Medications: _____

Supplements: _____

Broken Bones: ☐ Yes ☐ No Explain: _

Sprains: ☐ Yes ☐ No Explain: _

Hospitalized: ☐ Yes ☐ No Explain: _

Surgery: ☐ Yes ☐ No Explain: _

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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 _____

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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Totalhealth@drstevejones.com

Name _____

Date _____

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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NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

	Yes	No
a. Area between rectum and testicles (perineum)	☐	☐
b. Testicles	☐	☐
c. Tip of the penis (not related to urination)	☐	☐
d. Below your waist, in your pubic or bladder area	☐	☐

2. In the last week, have you experienced:

	Yes	No
a. Pain or burning during urination?	☐	☐
b. Pain or discomfort during or after sexual climax (ejaculation)?	☐	☐

3. How often have you had pain or discomfort in any of these areas over the last week?

- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Sometimes
- ☐ 3 Often
- ☐ 4 Usually
- ☐ 5 Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

☐ 0 NO PAIN ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

- ☐ 0 Not at all
- ☐ 1 Less than 1 time in 5
- ☐ 2 Less than half the time
- ☐ 3 About half the time
- ☐ 4 More than half the time
- ☐ 5 Almost always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- ☐ 0 Not at all
- ☐ 1 Less than 1 time in 5
- ☐ 2 Less than half the time
- ☐ 3 About half the time
- ☐ 4 More than half the time
- ☐ 5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

- ☐ 0 None
- ☐ 1 Only a little
- ☐ 2 Some
- ☐ 3 A lot

8. How much did you think about your symptoms, over the last week?

- ☐ 0 None
- ☐ 1 Only a little
- ☐ 2 Some
- ☐ 3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

- ☐ 0 Delighted
- ☐ 1 Pleased
- ☐ 2 Mostly satisfied
- ☐ 3 Mixed (about equally satisfied and dissatisfied)
- ☐ 4 Mostly dissatisfied
- ☐ 5 Unhappy
- ☐ 6 Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c,1d, 2a, 2b, 3, and 4 = _____

Urinary Symptoms: Total of items 5 and 6 = _____

Quality of Life Impact: Total of items 7, 8, and 9 = _____

Urogenital Distress Inventory (UDI-6 Short Form): UDI-6

1) Do you usually experience frequent urination? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

2) 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
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

3) Do you usually experience urine leakage related to coughing, sneezing, or laughing? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

4) Do you experience small amounts of urine leakage (that is, drops)? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

5) Do you experience difficulty emptying your bladder? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

6) Do you usually experience pain or discomfort in the lower abdomen or genital region? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
   If yes, then is your pain relieved after emptying your bladder? ☐ Yes ☐ No

No= 0, Not at all= 1, Somewhat= 2, Moderately= 3, Quite a bit= 4
Add all scores and multiply by 6 then multiply by 25 for the scale score
Missing items are dealt with by using the mean from the answered items only
Higher score = higher disability
Also see scoring of PFDI-20.

Uebersax JS, Wyman JF, Shumaker SA, McClish DK, Fantl AJ. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and the urogenital distress inventory. *Neurourol and Urodynam* 1995;14:131-139.

Grade A rating for symptoms of UI for women
Donavan J, et al Symptom and quality of life assessment. In Incontinence vol 1 Basics and Evaluation eds Abrams P, Cardozo L, Khoury S, Wein A. Health Publications Ltd Paris France 2005.

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Name: _____ Date: _____

Pain Disability Index

In order to determine how effective your treatment is, we need to know how much pain is interfering in your normal activities. For the 7 areas listed below, please circle the number on the scale which describes the level of disability you have experienced in each area OVER THE PAST WEEK. A score of "0" means no disability at all, and a score of "10" indicates that all of the activities which you would normally do have been totally disrupted or prevented by your pain over the past week. Circle "0" if a category does not apply to you.

Family/Home Responsibilities: This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g. yard work, house cleaning) and errands or favors for other family members (e.g. driving the children to school.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Social Activity: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as housewife or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Self-Care: This category includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed).

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Life-Support Activity: This category refers to basic life-supporting behaviors such as eating and sleeping.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Total Score: _____

Pain Disability Index 03-07

28

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.

Additionally, I give permission to share and discuss any and all medical information to:

Medical Provider / Relative / Other:

Name _____
Phone _____

Name _____
Phone _____

Name _____
Phone _____

Name of Patient or Legal Guardian _____

Signature of Patient or Legal Guardian _____

Date _____

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 $50 for chiropractic or regular physical therapy treatments or $75 for one-on-one physical therapy treatments.

Patient name: _____

Credit Card #_____CVV_____Exp. _____

Signature:_____Zip code _____

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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