Central Texas Myofascial Release

New Patient Information Sheet

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Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information. If a section does not apply please mark N/A.

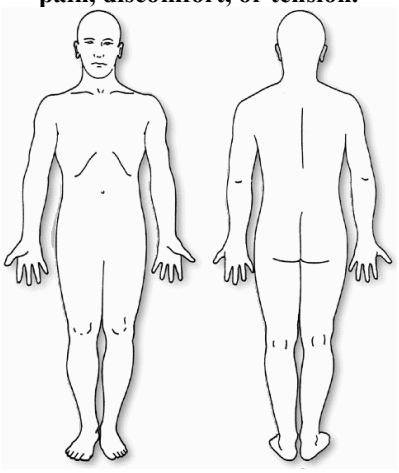
Name:	Last Name	First Name		Today's date:					
Address:									
City / State / ZIP:									
Phone #	MOBILE		HOME		WORK				
DOB:		Age:		Marital status:	M	S	W	D	
Email:									
Occupation:		Employer:							
Emergency Contact	Name:		Phone:						
Primary Care Physician	Name:		Date of next visit						
Specialist Physician	Name:		Date of next visit						

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Please shade in areas where you have pain, discomfort, or tension.



Please rate your pain in the last 24-72 hours **Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.**	At its worst	
	At its best	
	At present	
	Night (sleeping)	

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem? Ex: Surgery, Chiro, PT

List past medical history and dates of occurrence. Include chronic conditions, surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).

Medication	For treatment of	Dose / Amount per day	Effectiveness

Do you smoke?	Yes	No	If "Yes" – How much?	

Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

In general, your lifestyle is:	1	2	3	4	5
	Active		Average		Inactive

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).
If you are no longer able to perform an activity, your tolerance would be "0".

Task / Activity	Tolerance (minutes/hours)

Patient Goals
Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

Informed Consent

I understand that Central Texas Myofascial Release will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Photographs MAY be taken during initial evaluation, progress evaluation and discharge summary may be used for postural comparison purposes and as educational tools. By signing below I consent to the use of these photographs in a professional manner.

I do hereby agree and give my consent for Central Texas Myofascial Release to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature:_____

Date:_____

Cancellation and No Show Policy

All cancellations need to be made 24 hours prior to your appointment.
If you do not show up for your appointment or cancel with-in 24 hours, you will be responsible to pay for 100% of the session. **Initial**_____

Payment Policy

Physical Therapy sessions are $180/ session. Payment, in the form of cash, check or credit card, is due at the time of each visit.

We are not contracted with any insurance companies and are considered out of network. The payments you make may be reimbursable by your insurance company under your out of network physical therapy benefits; the exact percentage depends upon your plan. Due to the complex nature of insurance claims and reimbursement, I make no promises as to whether you will receive reimbursement.

We will assist you in every way possible. Payment is due at the time of service.

I have read and understand the above policies:

Name_____

Signature_____ Date_____

Thank you for your cooperation and business.

PELVIC FLOOR SPECIFIC QUESTIONS
Have you experienced or are you currently experiencing: (check all that apply)

	Bladder Urgency		Bladder Frequency		Urinary Leakage/Incontinence
	Fecal Incontinence		Voiding during the night		Constipation/IBS
	Interstitial Cystitis		Painful Intercourse		Pain following intercourse
	Pelvic Pain		Endometriosis		Fibroids/Cysts
	Painful Periods		Hemorrhoids		Frequent UTI
	Pregnancy: Number____		Vaginal Birth: Number____		C- Section: _____
	Abortion		Birth Weight of children:		
	Episiotomy		Tearing with childbirth		Pregnancy complications
	Erectile Dysfunction		Pain with Ejaculation		Scrotal/ Penis Pain
	History of Emotional/ Physical Abuse		History of Sexual Abuse		History of Sexual Assault

Average number of voids (urination) during the day_____

Average time between voids during the day _____

Average number of voids (urination) during the night _____

Average number of bowel movements a day_____

Do you feel you completely empty your bladder when you urinate? Y N

Do you feel you completely empty your bowels with bowel movements? Y N

Do you feel like something is falling into or out of your vagina? Y N

Any other Pelvic floor specific issues you would like assistance with? Please list:
