Pelvic Health New Patient Information

Central Texas Myofascial Release
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Name:	**Today's Date:**
Address:	**Date of Birth:**
	Age:
Phone Number:	**Referring Provider Name and Number:**
Email Address:	
Emergency Contact:	
Preferred Pronouns:	

Thank you for taking the time to answer the questions below. If there is anything you prefer not to answer, that is ok! If you would prefer to explain specific things to me in person, that is ok! If you feel like these questions are not getting quite to what you want me to know, tell me! These questions are general enough that they can apply to most, and designed to help me get a better picture of you, to tailor my assessment, and be a bit more efficient with our time together. No intake form is perfect and I respect you in your individuality. I will probably still ask you some of these things when we are face to face to get a more specific read, and you can let me know of anything more specific to you when we meet.

Describe the main issue that brings you here:

Any other physical issues that you have been dealing with?

How did you find me?

When did this issue first begin?

How is this issue impacting your physical life?

How is this issue impacting you emotionally/spiritually/sexually?

How do you hope that I can help you with this issue?

Have you tried other treatments for this? What/When? Were they helpful?

Do you have any concerns or questions about coming to see me (feel free to answer here or talk to me when you meet me!)

Are you currently having pain? Have you had pain in the past week?

Please list any medications you are currently taking and the condition for which you are taking them.

What does the physicality of your day typically look like? ie: I sit at a computer for work, I exercise doing x and y, I can barely get out of bed or off the couch, I am a mom to a toddler, etc.

If your main issue is Urinary Incontinence, Please go to https://centraltexasmfr.com/info/patient-resources/ and download and complete the CTMFR Bladder Diary prior to your visit.

General Health:

List any health conditions or complications that you have.

Are you being followed by a health care provider for these conditions?

Do you feel like your Mental Health is appropriately being addressed?

Do you feel like your Sexual Health is appropriately being addressed?

Surgical History: (yes, list all surgeries- even the stuff you don't think is relevant)

Pelvic History:

Are you experiencing or have you experienced any of these common pelvic oriented issues? (circle all that apply)

Bladder Urgency	Bladder Frequency	Urinary Leakage	Dribbling after urination
Shy Bladder	Incomplete Bladder Emptying	Frequent UTIs	Straining to empty bladder
Interstitial Cystitis	Dietary Sensitivity	Trouble initiating Urine Stream	Use of protective pads for urine leakage
Nighttime voiding	Hemmorhoids	Fecal Leakage	Neurological Condition
Constiptation	IBS	Incomplete Bowel Emptying	Childhood Constipation
Childhood Bedwetting	Smoking	Chronic Cough	Seasonal Allergies
Pelvic Pain	Sacroiliac Pain/ dysfunction	Painful Periods	Irregular Periods
Painful Intercourse	Pain after intercourse	Vaginal Dryness	Vulvovaginal burning
Vulvovaginal itching	Vulvodynia	Vulvar Dermatological Condition	Pelvic Organ Prolapse
Pelvic Inflammatory Disease	STI/STD	Infertility	Prostate Disorders
Penis/scrotal pain	Painful Ejaculation	Erectile Dysfunction	Headaches
Anxiety	Depression	Low Back Pain	Upper Back Pain
TMJ	Pelvic Organ Surgery	Back Surgery	Abdominal Organ Surgery
Emotional Abuse	Physical Abuse	Sexual Abuse	Sexual Assault

<u>Gynecologic History: (skip it it doesn't apply to you!!)</u>
Currently Menopausal?

Approximate age of First Period?

Are you currently having Periods?

Are your cycles regular?

Do you have pain at any part of your cycle? If so, when?

Do you feel your periods are abnormally heavy or light?

Total Number of Pregnancies? _____

Vaginal Deliveries #_____ Cesarian Deliveries#_____ Miscarriages #_____ Abortion #_____

Vaginal Delivery History: (Dates, Size of Baby, How long was labor/ pushing phases, complications, trauma, hospital/home/birthing center deliveries, etc)

Cesarian Section Delivery History: (Dates, Size of Baby, Reason for C Section, Complications, Any scar issues? Etc)

Have you ever had any issue with a Gynecological Exam or have issues prevented you from every having a Gynecologic Exam?

What forms of Birth Control have you used in the past and are you currently using?

Are you a nursing mother?

<u>Urology/ UroGyn History:</u>

Have you been seen by a Urologist/Urogynecologist?

Have you had any testing from Urology? If so, what, when and what were the results?

Have you been treated with antibiotics for Prostatitis? Was it Helpful?

Are your currently being treated by Urology?

INFORMED CONSENT

The term "informed consent: means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial list concerning the treatment and options available for my condition.

_____Initial at this and at the indicated lines below

_____ **Potential Risks:** I understand that I may experience an increase in my current level of pain or discomfort or an aggravation of my existing injury. This discomfort is usually temporary. If it does not subside in 24 hours, I agree to contact my therapist.

_____ **Potential Benefits:** May include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience decreased pain, improved flexibility, greater body awareness, and increased endurance for activities. I should also gain knowledge and confidence about my condition, its management, and resources available to me.

_____ **Alternatives:** I understand that there are always alternatives within my treatment. If I do not wish to participate in parts of my treatment plan, I will discuss this with my therapist. I can also discuss medical, surgical, or pharmacological alternatives with my therapist and my medical provider.

_____ 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, evaluation the quality of services provided and any administrative operations related to treatment or payment.

_____ 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 treatment 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 of the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature _____

Date: _____

PAYMENT POLICY

Physical Therapy sessions are $215 per 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 can make **no promises as to whether you will receive reimbursement.**

_____ **If you will be trying to submit to insurance please let me know at the BEGINNING of your first appointment** and I will provide a Superbill for you to submit.

_____ Central Texas Myofascial Release is **NOT A PROVIDER FOR MEDICARE**. I understand that no claim to Medicare may be made for services received at Central Texas Myofascial Release. We will do our best to refer those wanting to utilize Medicare Benefits to a participating group.

CANCELLATION, LATE, AND NO SHOW POLICY

Due to the demand and waitlist for provided services, please help me by respecting my cancellation, late and no show policies

_____ I understand that Central Texas Myofascial Release has reserved my scheduled treatment time for just for me.

_____ If I am late, I will be treated for the remainder of my scheduled time, but not beyond that time. I am still responsible for payment of 100% of the session. If I am submitting a Superbill, only actual treatment time will be entered on the Superbill which may affect reimbursement.

_____I understand that if I need to cancel, I must do so at least **24 hours** ahead of my scheduled appointment time or I will be responsible for 100% of my session.

_____ If I am ill the day of my scheduled session and can not come in, I will **CALL OR TEXT** Erin at 512-626-4048 by 8:30 AM. After that, I will be responsible to pay 100% of the session.

_____ If I do not show up to my appointment, I will be responsible to provide payment by credit card over the phone before my next scheduled session. I understand if I do not call, show, or respond to a follow up call or email within 48 hours, the remainder of my appointments will be cancelled.

I have read and understand the above policies:

Name_____ **Signature**_____ **Date**_____