Patient Information

Full Name: _____ Date of Birth: _____

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Primary Phone: _____ Alternate Phone: _____

Email: _____ Occupation: _____

How did you hear about Vitalize PT?: _____

Emergency Contact Information

Full Name: _____ Relationship: _____ Phone: _____

Medical History

Do you now have or have you ever had any of the following conditions?

	Now	Past		Now	Past
Asthmas / Bronchitis / Emphysema	_____	_____	Cancer	_____	_____
Shortness of Breath / Chest Pain	_____	_____	Arthritis	_____	_____
Heart Disease / Angina	_____	_____	Stroke / TIA	_____	_____
Heart Attack / Surgery / Pacemaker	_____	_____	Diabetes	_____	_____
High Blood Pressure	_____	_____	Gout	_____	_____
Anemia	_____	_____	Blood Clot / Emboli	_____	_____
Allergies	_____	_____	Infectious Diseases	_____	_____
Osteoporosis	_____	_____	Vision / Hearing Problems	_____	_____
Metal in Body / Surgical Implants	_____	_____	Thyroid / Goiter Problems	_____	_____
Anxiety / Depression	_____	_____	Dizziness / Fainting	_____	_____
Weight Loss / Gain	_____	_____	Hernia	_____	_____
Bowel / Bladder Problems	_____	_____	Joint Replacement	_____	_____

List all surgical procedures you have had:

_____

Other Conditions:

_____

Other Providers Currently Seeing _____

Medications / Supplements (please list all currently taking – use back side of page if needed)

_____

_____

CONDITIONS AND CONSENT FOR PHYSICAL THERAPY

PATIENT'S INITIALS	
	At Vitalize Physical Therapy we strive to provide you with the best, personalized care. To make this possible we ask you to adhere to the very important policies below. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.
	CONSENT FOR TREATMENT: I consent to and authorize my physical therapist to provide care and treatment prescribed by and considered necessary or advisable by the treating physical therapist and/or my physician(s). I acknowledge that no guarantees have been made to me about the results of treatment.
	ATTENDANCE/COMPLIANCE and CANCELLATION/NO SHOW POLICY: I understand that in order for physical therapy treatment to be effective, I must attend my scheduled appointments and arrive on time unless there are unusual circumstances that prevent me from attending therapy. Please call or text if you need to cancel. We have an ongoing waitlist and therefore require at least a 24 hour notice for cancellation or rescheduling of follow-up treatments and 48 hour notice for cancellation or rescheduling of initial evaluations. **No shows or cancellations less than 24 hours in advance for follow-up treatments or 48 hours in advance for initial evaluations will be charged the full visit fee.**
	PHYSICAL THERAPY SCRIPT/REFERRAL: You may have an evaluation and treatment for PT without a script/referral. However, **PLEASE NOTE: Indiana law requires a PT script within 42 days of initiating therapy.** You can obtain a script from a physician, podiatrist, psychologist, chiropractor, dentist, physician assistant or nurse practitioner. Additionally, if you plan to seek reimbursement from your insurance, your insurance provider may require a script PRIOR to beginning PT. For more information, please ask us to supply you with an "Insurance Benefit Worksheet" so you know how to inquire about your insurance out-of-network PT benefits.
	FINANCIAL POLICY: For optimal patient care, Vitalize Physical Therapy has chosen to be an out-of-network provider. By not having a preferred provider/contracted status with insurance companies, your PT does not have to limit the time or quality of treatment provided secondary to insurance company restrictions or elevate clinic rates to pay for billing services. Upon your request, we will give you a receipt of your services that you can submit to insurance for reimbursement if you have out-of-network insurance benefits or to apply toward your annual deductible. We accept cash, check, debit or credit card payment at the time of your service (cash or check is preferred). You may also use your Health Savings or Flex Spending Account to pay for your services. The rates are as follows: $200 for Initial Evaluation + Treatment (75 minutes) --- $160 for Follow-up Treatments (55 minutes).
	HIPPA AUTHORIZATION: We understand that health information about you is personal and we are committed to protecting it. We create a record of the care, services and assessments your receive from us. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice applies to all of the health related records of your care generated by Vitalize Physical Therapy, whether made by your personal treating practitioner or others working within Vitalize Physical Therapy. This Notice of Privacy Practices will tell you about the ways in which we may use and disclose health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to: • Make sure that health information that identifies you is kept private. • Give you this notice of our legal duties and privacy practices with respect to health information about you. • Not retaliate against you for filing a complaint.

I have read the above information, and I consent to physical therapy evaluation and treatment. I have asked any questions and they have been answered to my satisfaction. I understand the risks, benefits and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

CONSENT AND RELEASE FOR TRIGGER POINT DRY NEEDLING

Dry needling is a technique used in physical therapy practice to treat trigger points in muscles. Trigger points are hyperirritable spots in skeletal muscle associated with hypersensitive palpable nodule in a taut band. The technique is invasive and involves placing a needle into a muscle or muscles in order to release shortened bands of muscle and decrease trigger point activity. This can help resolve pain, muscle tension and promote healing. Dry needling is performed at Vitalize Physical Therapy by a licensed physical therapist that has received additional training in this technique. My physical therapist will monitor me during dry needling and use appropriate infection control procedures to reduce the risk of infection.

Dry needling as used in physical therapy is NOT ACUPUNCTURE, NOR IS THIS ANY FORM OF ACUPUNCTURE and should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist. A complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment. Patients interested in acupuncture should consult with a state licensed acupuncturist.

This form is a consent form and general release of medical liability for this procedure. By signing this form, you are agreeing not to hold Vitalize Physical Therapy and its staff liable for any complications that may arise from the practice of this procedure. Dry needling is a valuable addition to standard therapy for musculoskeletal pain. Like any treatment, there are risks and possible complications. While complications are rare, they are real and must be considered prior to giving consent for treatment.

POTENTIAL RISKS AND COMPLICATIONS OF PROCEDURE

Complications related to dry needling are rare and do not usually require additional medical treatment. The main risks and complications associated with dry needling include: bruising, bleeding, nerve injury, infection, fainting, and increased pain. In extremely rare cases, accidental puncture of a lung may occur that could require a chest x-ray and additional medical treatment/hospitalization.

Precautions for the use of dry needling include: pregnancy, malignant tumors, bleeding disorders, medical emergencies or in replace of surgical intervention, patients on blood thinners, unstable blood pressure, and internal organ diseases.

Please indicate if you have any of these precautions: _____

CONSENT AND RELEASE OF LIABILITY

I have read this informed consent carefully. I consent to and expressly and voluntarily assume the risks of my participation in this procedure. I will inform Vitalize Physical Therapy and my Physical Therapist of any questions or concerns I have concerning my treatment. I understand that no guarantee or assurance has been made as to the results of this procedure and that may not cure my condition. I certify that I am not experiencing that contraindications listed above. I agree to indemnify, defend and hold harmless, Vitalize Physical Therapy, its officers, agents, employees, affiliates, heirs, executors, administrators, agents, successors, and assigns from and against any and all liability, suits, losses, costs, expenses, or other claim of damage whatsoever, caused by or as a result of my participation in this treatment method. I have read, understand and agree to the terms of this consent. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I acknowledge that I am signing the agreement freely and voluntarily and intend by my signature to be complete and unconditional release of all liability to the greatest extent allowed by law.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

CONSENT FORM
INTERNAL PELVIC FLOOR EVALUATION

In order to fully understand the scope of your individual diagnosis, there is important information your physical therapist needs.

Please be brief in your answers. If your physical therapist needs you to expand upon your answers, she will ask you privately.

1. Are you currently sexually active? _____ YES _____ NO

   If "No", have you been in the past? _____ YES _____ NO

2. Do you have any communicable diseases? _____ YES _____ NO

   If "Yes", please explain: _____

3. Has there been any sexual abuse in your past? _____ YES _____ NO

4. Have you had difficulty in the past with vaginal exams? _____ YES _____ NO

I give / deny (circle one) my consent for the physical therapist to do a vaginal/rectal examination for the purpose of evaluating my condition and giving therapeutic treatment.

1. I understand I can terminate the procedure at any time.
2. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the procedure.
3. I have the option of bringing a second person to be in the room with me during the procedure, and I refuse / choose (circle one) this option.
4. I have read this consent form and understand it's terms.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

PELVIC QUESTIONNAIRE

PELVIC AND ABDOMINAL PAIN

WHERE IS YOUR PAIN: ☐ Vagina ☐ Vulva ☐ Pubic Bone ☐ Tailbone ☐ Sacrum ☐ SI Joint ☐ Lumbar ☐ Hip(s) ☐ Abdomen

DESCRIPTION: ☐ None ☐ Yes: ☐ Stabbing ☐ Aching ☐ Tender ☐ Sore ☐ Burning ☐ Prickling ☐ Sharp ☐ Shooting

WHAT INCREASES YOUR PAIN:

WHAT DECREASES YOUR PAIN:

TIME OF DAY: ☐ Unaffected MORNING: ☐ Increase ☐ Decrease AFTERNOON: ☐ Increase ☐ Decrease

EVENING: ☐ Increase ☐ Decrease NIGHTTIME: ☐ Increase ☐ Decrease

FULL BLADDER: ☐ Unaffected ☐ Increase ☐ Decrease

URINATION: ☐ Unaffected ☐ Increase ☐ Decrease

BOWEL URGE: ☐ Unaffected ☐ Increase ☐ Decrease

DURING BOWEL MOVEMENT: ☐ Unaffected ☐ Increase ☐ Decrease

AFTER A BOWEL MOVEMENT: ☐ Unaffected ☐ Increase ☐ Decrease

VAGINAL PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease

INITIAL PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease

DEEP PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease

ORGASM: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease

FOLLOWING PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase, Duration pain lasts:

ARE YOU ABLE TO ACHIEVE AN ORGASM? ☐ No ☐ Yes ☐ Unsure

MARINOFF SCALE – DESCRIPTIVE SCALE OF INTERCOURSE ☐ N/A

☐ 0: No problems ☐ 2: Pain interrupts or prevents completion

☐ 1: Discomfort that does not affect completion ☐ 3: Pain preventing any attempts at intercourse

CONTACT WITH CLOTHING: ☐ Unaffected ☐ Increase ☐ Decrease

ABDOMINAL PAIN OR BLOATING: ☐ N/A ☐ No ☐ Yes. Explain:

DIGESTIVE ISSUES? ☐ No ☐ Past ☐ Present. Explain:

☐ Food Allergy or Intolerance ☐ IBS ☐ IBD ☐ Leaky Gut ☐ SIBO ☐ Candida Overgrowth ☐ Colon Dysbiosis
☐ Ulcerative Colitis ☐ Crohn's ☐ Other:

PAIN FROM EATING: ☐ No ☐ Yes. Explain:	PAIN FROM DRINKING: ☐ No ☐ Yes. Explain:

RATE YOUR PAIN (0=NONE, 10=WORST PAIN IMAGINABLE)? Current: _____ /10 At best?: _____ /10 At worst?: _____ /10

OBSTETRICS/GYNECOLOGICAL HISTORY

ARE YOU CURRENTLY PREGNANT? ☐ No ☐ Yes. DUE DATE: _____/_____/_____ NUMBER OF WEEKS GESTATION: _____	
IF PREGNANT, ARE YOU HIGH RISK? ☐ No ☐ Yes	DO YOU HAVE MTHFR? ☐ No ☐ Yes. Explain:
CURRENT PRENATAL SUPPLEMENTS:	
NUMBER OF PREGNANCIES: _____ NUMBER OF DELIVERIES: VAGINAL _____ C-SECTION _____ V-BACK _____	
DATES OF DELIVERIES: ____/_____/_____ , ____/_____/_____ , ____/_____/_____ , ____/_____/_____ , ____/_____/_____	
BIRTH WEIGHTS:	CURRENTLY BREASTFEEDING? ☐ No ☐ Yes
EPISIOTOMY OR PERINEAL TEAR? ☐ No ☐ Yes. Explain:	DIFFICULT CHILDBIRTH? ☐ No ☐ Yes. Explain:
POST PARTUM DEPRESSION OR BABY BLUES? ☐ No ☐ Yes ☐ Unsure. Explain:	
DO YOU HAVE DIASTASIS RECTI? ☐ No ☐ Yes ☐ Unsure. Explain:	
DIFFICULTY CONCEIVING? ☐ No ☐ Yes. Explain:	# OF MISCARRIAGES _____ # OF INFANT LOSSES _____ # OF ABORTIONS _____
MENSTRUATION: ☐ N/A CYCLE LENGTH: _____ Days DURATION OF PERIOD (BLEEDING): _____ Days	PAINFUL PERIODS? ☐ No ☐ Yes. Explain:
VAGINAL DRYNESS? ☐ No ☐ Yes. Explain:	CURRENTLY ON BIRTH CONTROL? ☐ No ☐ Yes. Name: TOTAL MONTHS/YEARS ON BIRTH CONTROL: _____
DATE OF LAST PELVIC EXAM: _____/_____/_____ RESULTS:	MENOPAUSE? ☐ No ☐ Yes. Explain:
HISTORY OF PHYSICAL OR SEXUAL ABUSE? ☐ No ☐ Yes. Explain:	
HISTORY OF STD's CURRENT OR PAST? ☐ No ☐ Yes. Explain: IF PAST, PLEASE LIST CURE DATE: _____/_____/_____	
CURRENT YEAST INFECTION? ☐ No ☐ Yes	HISTORY OF YEAST INFECTIONS? ☐ No ☐ Yes. How many? _____
CURRENT URINARY TRACT INFECTION (UTI)? ☐ No ☐ Yes	HISTORY OF UTI's? ☐ No ☐ Yes. How many? _____
DO YOU USE LATEX CONDOMS? ☐ No ☐ Yes	DO YOU USE VAGINAL LUBRICANTS? ☐ No ☐ Yes. Brand(s)?
DO YOU USE BATH SALTS, VAGINAL SPRAYS, DOUCHES? ☐ No ☐ Yes. Explain:	DO YOU USE ANY OTHER VAGINAL CREAMS OR MEDICINE? ☐ No ☐ Yes. Explain:

BLADDER

WAS THERE AN EVENT ASSOCIATED WITH ONSET OF URINARY COMPLAINTS?: ☐ No ☐ Yes. Please describe:

URINE STREAM: ☐ Easy to Start ☐ Difficult to Start ☐ Strong ☐ Weak ☐ Starts & Stops ☐ Deflects to one side

EMPTYING: ☐ Complete ☐ Incomplete ☐ Pushing or straining needed ☐ Retention ☐ Other: _____

ANY DRIBBLING AFTER URINATION?: ☐ No ☐ Yes

FREQUENCY OF URINATION: During awake hours? _____ # times per day During Sleep Hours? _____ # times per night

DO YOU FEEL AN INTENSE URGE TO URINATE? ☐ No ☐ Yes ☐ Unsure

URINARY SENSATION PRESENT:
☐ No ☐ Yes ☐ Variable ☐ Sense of "urgency"

ONCE YOU GET THE URGE, CAN YOU HOLD BACK FROM VOIDING?:
_____ minutes, _____ hours

COLOR OF URINE:

WHAT IS THE AVERAGE VOLUME OF URINATION?
Specify oz OR count seconds
☐ _____ oz ☐ _____ seconds

WHAT DO YOU DRINK?

CUPS OR FL OZ OF WATER PER DAY?

CAFFEINE? ☐ None ☐ Yes, Please describe:

CAN YOU STOP YOUR URINE ONCE STARTED?:
☐ Complete ☐ Deflects ☐ Unable

DO YOU KEGEL WHEN YOU URINATE?
☐ No ☐ Yes ☐ Sometimes

PAIN OR BURNING WITH URINATION?: ☐ No ☐ Yes

PAIN WITH WIPING?: ☐ No ☐ Yes

HOW DO YOU WIPE? ☐ Front to back ☐ Back to front ☐ Other. Explain:

PROLAPSE OR FEELING OF FALLING OUT OR HEAVINESS IN PELVIS: ☐ No ☐ Yes
☐ With Menses ☐ Standing ☐ Straining ☐ At the end of the day ☐ All the time

DO YOU VOID "JUST IN CASE"?: ☐ No ☐ Yes

DO YOU HOVER OVER PUBLIC TOILETS TO VOID: ☐ No ☐ Yes

DID YOU EXPERIENCE ANY URINARY ISSUES AS A CHILD ☐ No ☐ Yes. Please describe:

URINARY LEAKAGE

URINARY LEAKAGE: _____ # episodes per ☐ Day ☐ Week ☐ Month

CAUSE: ☐ None ☐ Cough ☐ Sneeze ☐ Laugh ☐ Lift ☐ Sit<>Stand ☐ Walking ☐ Jumping ☐ Running

☐ On the way to the bathroom ☐ Sound of running water ☐ Key in the door ☐ Other: _____

URINE LEAKAGE AMOUNT: ☐ None ☐ Few Drops ☐ Wets Pad ☐ Wets Underwear ☐ Wets Outerwear

DO YOU WEAR A PAD OR PROTECTIVE DEVICE?:
☐ No ☐ Yes. What kind?

PAD(S) CHANGES REQUIRED IN 24 HOURS:

HAVE YOU EVER TAKEN MEDICINE TO PREVENT URINE LOSS: ☐ No ☐ Yes. Explain:

BOWEL HABITS

WAS THERE AN EVENT ASSOCIATED WITH ONSET OF BOWEL COMPLAINTS?: ☐ No ☐ Yes. Please describe:	
BOWEL SENSATION PRESENT?: ☐ No ☐ Yes ☐ Variable	CAN YOU HOLD BACK YOUR FECES IF NO BATHROOM IS AROUND?: minutes, hours
FREQUENCY OF BOWEL MOVEMENTS: **#** times per day, **#** times per week	
EVACUATION HABITS: ☐ Hold Breath ☐ Straining ☐ Splinting ☐ Other Explain:	
COLOR OF YOUR POOP:	IS YOUR STOOL: ☐ LIQUID ☐ SOFT ☐ NORMAL ☐ FIRM ☐ HARD
LAXATIVE USE: ☐ None ☐ Yes. How often per week?	ANY BLOOD ON TISSUE AFTER BOWEL MOVEMENT?: ☐ No ☐ Yes
DID YOU EXPERIENCE ANY BOWEL ISSUES AS A CHILD ☐ No ☐ Yes. Please describe:	
FECAL LEAKAGE: _____ **#** episodes per ☐ Day ☐ Week ☐ **M**onth	CAUSE OF FECAL LEAKAGE: ☐ N/A ☐ Explain:
FECAL LEAKAGE AMOUNT: ☐ None ☐ Smear ☐ Diarrhea ☐ Few "Pebbles" ☐ Full Stool	
FORM OF PROTECTION: ☐ None ☐ Yes. What type of pad?:	# PAD CHANGES REQUIRED IN 24 HOURS: _____

LIFESTYLE / QUALITY OF LIFE / FUNCTIONAL LIMITATIONS

SOCIAL ACTIVITIES: ☐ Unaffected ☐ Affected. Explain:
DIET/FLUID INTAKE: ☐ Unaffected ☐ Affected. Explain: CURRENT DIET:
DRUG, ALCOHOL, TOBACCO USE: ☐ None ☐ Yes. Explain:
PHYSICAL ACTIVITY: ☐ Unaffected ☐ Affected. Explain: CURRENT PHYSICAL ACTIVITY:
WORK: ☐ N/A ☐ Unaffected ☐ Affected. Explain: CURRENT JOB:
OTHER (SPECIFY): ☐ N/A ☐ Affected. Explain:
PATIENT GOALS:

Vitalize
physical therapy

ORTHOPEDIC QUESTIONNAIRE

What are you primary concerns with seeking physical therapy?

_____

How long have you been having symptoms/when did your symptoms begin?

_____

Was it a gradual onset or sudden?

_____

What do you think caused your injury/pain/issue?

_____

Where did the pain start? Where is it now?

_____

What makes your symptoms better? (ex: ice, heat, meds, rest, positions, movement) Please explain:

_____

What makes your symptoms worse? (ex: positions/postures, bending, reaching, lifting, deep breathing, coughing, sitting, standing, walking, household chores, recreational activities, sports, etc.) Please explain:

_____

When do you typically feel the pain? (Circle: morning, mid-day, end of day, night) Please explain:

_____

On a scale of 0-10 (0=no pain,10=worst imaginable pain), what is your pain now? ____/10; Least? ____/10; Worst? ____/10
Describe your pain (Circle: dull, aching, sore, tender, stabbing, sharp, shooting, radiating, tingling, burning, numbness), Other:

_____

Do you have any other symptoms associated with the pain such as locking, popping, weakness, etc?

_____

Have you had any abnormal symptoms: (ex: unexpected weight loss or weight gain, changes in bowel or bladder function, abnormal sensation in perianal/buttock/posterior upper thigh, vertigo or dizziness, unprovoked falls without warning) Explain:

_____

Circle treatment received for this condition (underline if effective): chiropractic acupuncture injections PT OT massage

Have you had any imaging (x-ray, MRI, CT scan) related to this issue?

_____

Are you taking any medications for this condition? If so, when did you last take them?

_____

Have you ever had this issue in the past? Is it the same now as it was then? Did you seek help? Did it improve or resolve?

_____

Do you have a past or present history of illness?

_____

What is your job? Has this affected your ability to do your work?

_____

Tell me about your general health/lifestyle/, activity/exercise, and alcohol, drug, and/or tobacco use:

_____

History of car accident, trauma, and/or abuse (including verbal, emotional, physical, sexual)? Please Explain:

_____

Have you been experiencing any life or economic stresses? Please Explain:

_____

What is your #1 concern as we address this problem?

_____

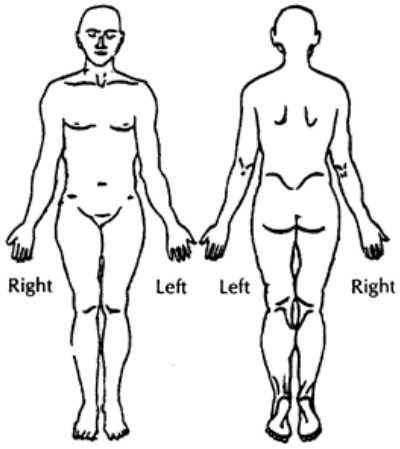
What are your top goals in coming to physical therapy?

_____

Is there anything else you would like to tell me?

_____

Please Circle or Mark ALL the areas below that are painful or uncomfortable:



Please write a time line of your condition(s) in chronological order. Details of your past can be very helpful in figuring out the root cause of your current issue, leading to quicker results for your recovery (prior pain, surgeries, falls, significant illness, traumatic events, abuse, accidents and injuries can all play a role). Feel free to use the backside of this paper if needed.

_____

_____

_____