Gainesville Physical Therapy & Wellness

"Where People Matter and Results Count"

Patient Information Page 1 of 2

*We cannot process your insurance claims without the required fields filled out.

Patient's Name*:_____ Today's Date: _____
Street address*:_____ SSN*:_____
City and State*:_____ Zip Code*:_____
Gender at Birth: _____ Gender Identity: _____
Date of Birth: _____ Age: _____ Email: _____
Primary Phone: _____ Secondary Phone: _____
Can we communicate with you about appointments, reminders, billing updates, medical records, etc. by (check all that apply): ☐Text ☐Email ☐Voicemail
Referring Physician: _____ Phone Number: _____
Family Physician: _____ Phone Number:_____
Person to contact in case of emergency/authorized to speak to:_____
Contact Phone Number:_____ Relationship to patient:_____
Is emergency contact authorized to review information: ◯ Yes ◯ No

Primary Insurance Company Name: _____

Policy Number: _____ Group Number: _____
Insurance Company Claims Billing Address: _____
Policyholder's name:_____ Relationship to patient:_____
Policy holder's date of birth:_____ Gender on Insurance: ◯ Male ◯ Female

Secondary Insurance Company Name: _____

Policy Number:_____ Group Number: _____
Insurance Company Claims Billing Address: _____
Policyholder's name:_____ Relationship to patient:_____
Policy holder's date of birth:_____ Gender on Insurance: ◯ Male ◯ Female

Is this a Worker's Compensation Claim? ◯ Yes ◯ No

Date of Injury:_____ Company Name:_____
Claim #:_____ Address:_____
Adjustor's Name:_____ Phone Number: _____

Is this an Auto Accident Case? ◯ Yes ◯ No

Date of Accident: _____ Company Name: _____
Claim #:_____ Address: _____
Adjustor's Name:_____ Phone Number: _____

Is there a pending litigation concerning your injury? ◯ Yes ◯ NO If Yes, name of attorney_____
Address:_____ Phone Number:_____

How did you obtain our name?

◯ Friend ◯ Physician ◯ Internet ◯ Website ◯ Other:_____

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Patient Information Page 2 of 2

I consent to Gainesville Physical Therapy & Wellness, LLC for treatment/procedures that are necessary or advisable for my care. I hereby grant authorization to Gainesville Physical Therapy & Wellness, LLC to exchange with and/or release requested information regarding my medical care to my insurance carrier (s) and to:

◯Workers Compensation ◯Patient/Guardian ◯Attorney ◯Rehab Intermediary

Write the names of those you are allowing to share your information with below & place your initials next to their names.

Name:_____ Initials: _____
Name:_____ Initials: _____
Name:_____ Initials: _____

Please initial the statements below indicating agreement and understanding!

_____ I certify that the information furnished by me is correct and I hereby direct and authorize payment of health care benefits due me by insurer to Gainesville Physical Therapy & Wellness, LLC. I also certify that I have received the Policy and Procedures from Gainesville Physical Therapy & Wellness, LLC

_____ I have read and understand Gainesville Physical Therapy & Wellness, LLC's privacy notice. I further understand that I may obtain a copy of this HIPAA privacy notice upon my request.

_____ I understand that if I **no show or do not cancel my appointment 24 hours** in advance that there is a **$35 charge**, which is **NOT COVERED** by insurance. (This also applies to worker's comp patients.) I further understand that I may obtain a copy of this policy upon request.

_____ **I understand that I am financially responsible for payment of fees regardless of insurance coverage.** I understand that my insurance is my responsibility. We verify your benefits and simply relay the information obtained from your insurance company to you. GPTW is **NOT responsible** for any erroneous information your insurance company may provide. Please contact your insurance company with any questions you may have.

Clients Signature:_____ Date:_____

Responsible Party's Signature (if patient is a minor):_____

_____

Witness Print Name Witness Signature Date

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Women's Health Questionnaire

Patient's Name: _____ Date:_____

Describe the reason for your appointment:_____

_____

When did this problem begin?_____ The problem is: ○ getting better ○ worse ○ same

1. Bladder leakage frequency:

○ Never ○ Only with strong cough or sneeze ○ Only premenstrual

Number of Episodes: per month: _____ per week: _____ per day: _____

2. Severity of leakage:

○ No leakage ○ Few Drops ○ Wets Underwear ○ Wets outerwear

3. Protection worn:

○ None ○ Tissue paper or paper towel ○ Panti shields ○ Mini pads ○ Maxi pad ○ Diaper

Average # per day: _____

4. Leakage caused by or increased by: (select all that apply)

○ Vigorous activity or exercise (Running, weight lifting, cough/sneeze/laugh)	○ Intercourse or sexual activity
○ Light activity (Walking, light house work)	○ No activity changes leakage (constant leakage)
○ Changing positions (sitting to standing)	○ After emptying bladder
○ Walking to the toilet	○ Washing hands
○ Strong urge to go	○ Putting key in lock
Other, please list:	

5. Position or activity with leakage?

○ Lying down ○ Sitting ○ Standing ○ Squatting

6. Do you feel a "falling out" or pelvic heaviness/pressure?

○ None	○ Only with menstruation
○ With standing	○ With exertion or straining
○ At the end of each day	○ Present all day

How often do you feel these symptoms? _____

7. Fluid intake (one glass is 8oz or one cup)

# of glasses per day: _____

# of caffeinated glasses per day: _____

# of alcoholic beverages per day: _____

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8. Rate your feeling as to the severity of this problem from 0-10.

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

not a problem major problem

9. Rate the following statement as it applies to you today: "My bladder is controlling my life"

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

not true at all completely true

BLADDER HABITS:

1. How often do you urinate during the day? _____# of times/day
2. How often do you urinate after going to bed? _____# of times at night
3. Do you take your time to go to the toilet and empty your bladder? ○Yes ○No
4. Number of bladder infections in the last year? _____
5. Can you stop the flow of urine when on the toilet? ○Yes ○No
6. Is the volume of urine passed usually? ○Large ○Average ○Small ○Very Small
7. Do you have the sensation that you need to go to the toilet? ○Yes ○No
8. Do you strain to pass urine? ○Yes ○No
9. Do you empty your bladder frequently, before you experience the urge to pass urine? ○Yes ○No
10. Do you have the feeling your bladder is still full after urinating? ○Yes ○No
11. Do you have a slow hesitant urinary stream? ○Yes ○No
12. Do you have difficulty initiating the urine stream? ○Yes ○No
13. Do you have "trigger" that make you feel like you can't wait to go to the toilet? (running water, etc) ○Yes ○No Please list: _____
14. How long can you delay the need to urinate?

○ Not at all ○ 1-2 Min ○ 3-10 min ○ 11-30 min ○ 31-60 min ○ ___ Hours

BOWEL HABITS:

15. Frequency of bowel movements: ____ per day _____ per week
16. Consistency of stool: ○Loose ○Normal ○Hard
17. History of constipation? ○Yes ○No
18. Do you currently strain to go? ○Yes ○No
19. Do you ignore the urge to defecate? ○Yes ○No
20. Do you have trouble making it to the toilet on time when you have the urge to go? ○Yes ○No

Past level of function: BEFORE this problem began your activities were:

○Normal and unrestricted
○Minimally restricted
○Moderately restricted
○Severely restricted
○Only heavy activities are restricted

Present level of function: AFTER this problem began your activities were:

○Normal and unrestricted
○Minimally restricted
○Moderately restricted
○Severely restricted
○Only heavy activities are restricted

Specifically, what are you not able to do because of your current problem? _____

_____

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Incontinence Impact Section

Patient's Name: _____ Date:_____

Has urine leakage affected your:	Not at all (0)	Slightly (1)	Moderately (2)	Greatly (3)
Ability to do household chores (cooking, housecleaning, laundry)?	○	○	○	○
Physical recreation such as walking, swimming, or other exercise?	○	○	○	○
Entertainment activities (movies, concerts, etc.)	○	○	○	○
Ability to travel by car or bus more than 30 minutes from home?	○	○	○	○
Participation in social activities outside your home?	○	○	○	○
Emotional health (nervousness, depression etc.)	○	○	○	○
Feeling frustrated?	○	○	○	○

Do you experience any urinary incontinence? ○Yes ○No

If so, how much are you bothered by:	Not at all (0)	Slightly (1)	Moderately (2)	Greatly (3)
Frequent urination	○	○	○	○
Urine leakage related to feeling of urgency	○	○	○	○
Urine leakage related to physical activity, coughing or sneezing?	○	○	○	○
Small amounts of urine leakage?	○	○	○	○
Difficulty emptying your bladder?	○	○	○	○
Pain or discomfort in the lower abdomen or genital area?	○	○	○	○

Do you have any uncontrolled leakage of ○gas ○liquid ○solid stool ○none?

On a scale of 0 to 100, where zero represents death and 100 represents perfect health, please indicate how you would rate your current state of health: ___ ___ ___ (1-100)

For Therapist Use:_____

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Patients Current Health History Page 1 of 3

I live: ◯ Alone ◯ Spouse Only ◯ Spouse and Other(s) ◯ Child (not spouse) ◯ Other Relative (not spouse or child) ◯ Group Setting ◯ Personal Care Attendant

Have you completed an advance directive? ◯ Yes ◯ No

PAST MEDICAL HISTORY: Have you EVER been diagnosed with any of the following conditions or have you recently experienced any of the following?

◯ Yes	◯ No	Allergies	◯ Yes	◯ No	Kidney Problems
◯ Yes	◯ No	Anemia	◯ Yes	◯ No	Metal Implants
◯ Yes	◯ No	Anxiety	◯ Yes	◯ No	MRSA
◯ Yes	◯ No	Arthritis (Not RA)	◯ Yes	◯ No	Multiple Sclerosis
◯ Yes	◯ No	Autoimmune Disorder	◯ Yes	◯ No	Muscular Disease
◯ Yes	◯ No	Cancer	◯ Yes	◯ No	Osteoporosis
◯ Yes	◯ No	Cardiac Conditions	◯ Yes	◯ No	Parkinsons
◯ Yes	◯ No	Cardiac Pacemaker	◯ Yes	◯ No	Rheumatoid Arthritis
◯ Yes	◯ No	Chemical Dependency	◯ Yes	◯ No	Seizures
◯ Yes	◯ No	Circulation Problems	◯ Yes	◯ No	Smoking
◯ Yes	◯ No	Depression	◯ Yes	◯ No	Speech Problems
◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Strokes
◯ Yes	◯ No	Dizzy Spells	◯ Yes	◯ No	Thyroid Disease
◯ Yes	◯ No	Emphysema/Bronchitis	◯ Yes	◯ No	Tuberculosis
◯ Yes	◯ No	Fibromyalgia	◯ Yes	◯ No	Vision Problems
◯ Yes	◯ No	Fractures	◯ Yes	◯ No	Polio
◯ Yes	◯ No	Gallbladder Problems	◯ Yes	◯ No	Fever/Sweats/Chills
◯ Yes	◯ No	Headaches	◯ Yes	◯ No	Nausea or Vomiting
◯ Yes	◯ No	Hearing Impairment	◯ Yes	◯ No	Weight Gain/Loss
◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No	Sleep Apnea
◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Fatigue
◯ Yes	◯ No	High/Low Blood Pressure	◯ Yes	◯ No	Weakness
◯ Yes	◯ No	HIV/AIDS	◯ Yes	◯ No	Numbness/Tingling
◯ Yes	◯ No	Incontinence	Other:		

How many caffeine containing beverages do you drink per day? _____

How many days per week do you drink alcohol?_____

How many packs of cigarettes do you smoke per day?_____

Please list any allergies:_____

What kind of exercise do you do? How often? _____

_____

Print Patient Name Signature Date

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Patients Current Health History Page 2 of 3

Pick a number 0-4 to measure how much you agree with the following statements. (0 is completely agree, 4 meaning completely disagree)

	0	1	2	3	4
"I worry all the time about whether the pain will end"	○	○	○	○	○
" I keep thinking about how much it hurts."	○	○	○	○	○
"There is nothing I can do to reduce the intensity of the pain."	○	○	○	○	○

Which of the following over-the-counter medications have you taken in the last week?

○ Yes	○ No	Asprin	○ Yes	○ No	Antihistamines
○ Yes	○ No	Tylenol	○ Yes	○ No	Antacid
○ Yes	○ No	Advil/Motrin/Ibuprofen	○ Yes	○ No	Decongestants
○ Yes	○ No	Laxatives	○ Yes	○ No	Vitamins/Supplements
Other:					

List Vitamins/Supplements:

_____

_____

Please list any PRESCIPTIONS you are currently taking (including Pills, Injections, etc.) and explain what they are used for.

Medication	Dosage	Frequency	Route	Reason

☐ See attached list

Do any of your medications cause you to be dizzy or to lose your balance? ○ Yes ○ No

_____

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Patients Current Health History Page 3 of 3

Injuries, Hospitalizations, Surgeries

Please describe all injuries and any surgeries for which you have been treated:

Injury/Surgery/Hospitalization	Date	Reason

Has anyone in your immediate family (parents, brothers, sisters) been treated for any of the following?

Yes	No	Diabetes	Yes	No	Headaches
Yes	No	Stroke	Yes	No	Epilepsy
Yes	No	Kidney Disease	Yes	No	Mental Illness
Yes	No	Chemical Dependency (Alcoholism)	Yes	No	Cancer
Yes	No	Tuberculosis	Yes	No	Arthritis
Yes	No	Heart Disease	Yes	No	Anemia
Yes	No	High Blood Pressure	Yes	No	Sleep Apnea

At the present time, would you say your health is: Excellent Very Good Fair Poor
During the past month have you been feeling down, depressed or hopeless? Yes No
During the past month have you had little interest/pleasure in doing things? Yes No
Do you ever feel unsafe at home, been hit, or has someone tried to injure you in any way?
Yes No

_____

Print Patient Name Signature Date

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