Pelvic Health

GAINESVILLE PHYSICAL THERAPY & Wellness

Gainesville Physical Therapy & Wellness
4113 NW 6th St. Ste C
Gainesville, Fl 32609
P: 352-376-6300
F: 352-372-0661

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@Birth: _____
Gender Identity: _____ Preferred Pronouns: _____
Date of Birth*: _____ Age: _____ Email: _____
Primary Phone: _____ Secondary Phone: _____
GPTW may contact me by phone, email, or text. I understand that these forms of communication are not secure and accept any risk involved in using them.

- Initial here _____ **ONLY** if you want to request that all communications from GPTW be via fax or United States mail only. Fax #: _____

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

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Primary Insurance Company Name: _____
Policy Number: _____Policyholder's name (if not patient): _____
Relationship to patient:_____ Policyholder's date of birth: _____

Secondary Insurance Company Name: _____
Policy Number: _____Policyholder's name (if not patient): _____
Relationship to patient:_____ Policyholder's date of birth: _____

Is this a Worker's Compensation Claim? ◯ Yes ◯ No
Date of Injury:_____ Company Name:_____
Claim #:_____ Adjustor's Name:_____ Phone Number: _____

Is this an Auto Accident Case? ◯ Yes ◯ No
Date of Accident: _____ Company Name: _____
Claim #:_____ Adjustor's Name:_____
Phone Number: _____
Do you have an attorney concerning your injury? ◯ Yes ◯ No Attorney:_____
Law Office:_____ Phone: _____ Fax: _____

Have you had home health in the last 90 days? ◯ Yes ◯ No Agency: _____
You must be discharged from home health before your insurance will cover our PT claims

How did you obtain our name?
◯ Friend ◯ Physician ◯ Internet ◯ Website ◯ Other:_____

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Patient Information Page 2 of 2

I authorize to Gainesville Physical Therapy & Wellness, LLC to provide 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: _____

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 read and understand the Policies and Procedures as well as the Privacy Notice from Gainesville Physical Therapy & Wellness, LLC and that I may obtain a copy upon my request (located on the website under Forms).

_____ I understand that if I **NO SHOW or do not CANCEL my appointment 24 hours** in advance that there is a **$50 charge**, which is **NOT COVERED** by insurance.

_____ **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 as a courtesy to you 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 Printed Name Witness Signature Date

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Patient Current Medical History Form Page 1 of 2

A complete medical history is necessary for a thorough evaluation. Please answer the following
What activities are you currently **NOT ABLE** to do because of your problem? _____
_____

Currently Pregnant: ◯ Yes ◯ No **Months**:_____

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 week _____ Per day: _____

2. Severity of leakage:
◯ No leakage ◯ Few Drops ◯ Wets Underwear ◯ Wets Outerwear

3. Protection Worn
◯ None ◯ Tissue paper or paper towel ◯ Panty Shields ◯ Mini pads ◯ Maxi pads ◯ Max Brief

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)
☐ Changing positions (sitting or standing)	☐ After emptying bladder
☐ Walking to the toilet	☐ Washing hands
☐ Strong urge to go	☐ Putting key in lock
Other:	

5. Position or activity with leakage? ☐ Lying Down ☐ Sitting ☐ Standing ☐ Squatting

6. 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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Patient Current Medical History Form Page 2 of 2

Bladder Habits

1. How often do you urinate during the day? _____# of times a day
2. How often do you urinate after going to bed? _____# of times a day
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 a "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 to go? ◯ Yes ◯ No

Past level of function: BEFORE this problem	Present level of function: WITH this problem
◯ Normal and unrestricted	◯ Normal and unrestricted
◯ Minimally restricted	◯ Minimally restricted
◯ Moderately restricted	◯ Moderately restricted
◯ Severely restricted	◯ Severely restricted
◯ Only heavy activities are restricted	◯ Only heavy activities are restricted

_____

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Patient 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

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	Incontinence
◯ Yes	◯ No	Anemia	◯ Yes	◯ No	Kidney Problems
◯ Yes	◯ No	Anxiety	◯ Yes	◯ No	Metal Implants
◯ Yes	◯ No	Arthritis (Not RA)	◯ Yes	◯ No	MRSA
◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Multiple Sclerosis
◯ Yes	◯ No	Autoimmune Disorder	◯ Yes	◯ No	Muscular Disease
◯ Yes	◯ No	Cancer	◯ Yes	◯ No	Osteoporosis
◯ Yes	◯ No	Cardiac Conditions	◯ Yes	◯ No	Parkinson's
◯ Yes	◯ No	Cardiac Pacemaker	◯ Yes	◯ No	Rhuematoid Arthritis
◯ Yes	◯ No	Chemical Dependency	◯ Yes	◯ No	Seizures
◯ Yes	◯ No	Circulation Problems	◯ Yes	◯ No	Smoking
◯ Yes	◯ No	COVID19	◯ Yes	◯ No	Speech Problems
◯ Yes	◯ No	Depression	◯ Yes	◯ No	Strokes
◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Thyroid Disease
◯ Yes	◯ No	Dizzy Spells	◯ Yes	◯ No	Tuberculosis
◯ Yes	◯ No	Emphysema/Bronchitis	◯ Yes	◯ No	Vision Problems
◯ Yes	◯ No	Fibromyalgia	◯ Yes	◯ No	Polio
◯ Yes	◯ No	Fractures	◯ Yes	◯ No	Fever/Sweats/Chills
◯ Yes	◯ No	Gallbladder Problems	◯ Yes	◯ No	Nausea or Vomiting
◯ Yes	◯ No	Headaches	◯ Yes	◯ No	Weight Gain/Loss
◯ Yes	◯ No	Hearing Impairment	◯ Yes	◯ No	Sleep Apnea
◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No	Fatigue
◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Weakness
◯ Yes	◯ No	High/Low Blood Pressure	◯ Yes	◯ No	Numbness/Tingling
◯ Yes	◯ No	HIV/AIDS	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? _____
_____

_____

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Patient Current Health History Page 2 of 3

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

◯ See Attached List

Medication	Dosage	Frequency	Route: Oral, Nasal, Inject, etc.	Reason

Over the Counter ◯ Aspirin ◯ Advil/Motrin/Ibuprofen ◯ Aleve ◯ Tylenol/Acetaminophen
Do any of your medications cause you to be dizzy or to lose your balance? ◯ Yes ◯ No

List Vitamins/Supplements:

_____

_____

_____

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

_____

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Injuries, Hospitalizations, Surgeries

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

Injury/Surgery/Hospitalization	Date	Reason

Print Patient Name Signature Date