Board Certified Pelvic Physical Therapy

BACK in MOTION

Men Women Children

10789 Double R Blvd, Suite #100
Reno, NV 89521
Phone: (775)746-2206
Fax: (775)359-3332
admin@backinmotion.net
www.backinmotion.net

Patient Information

Please Print Clearly: **Today's Date:**________________

Patient Name: ______________________________ SS#: ____________ DOB: ____________

Address: ______________________________ City: __________ State: ____ Zip:__________

Employer: ______________________________ Occupation: ________________________

Employer Address: ________________________ City: __________ State: ____ Zip: __________

Best Phone Contacts: Primary: ____________________ Secondary: ________________________

Email: ____________________________________ May we contact you by ◯ Text or ◯ Email?

Referring Source: __________________________ How did you hear about us?________________

Are you 18 and/or a dependent on a guardian's insurance? ◯ Yes / ◯ No

If yes, Guardian's Name: ________________________Emergency Contact:__________________

Insurance/Billing Information

Primary Insurance:______________________ Insured Name: __________________________
Group#_________________________ Address:_______________________City:________
Insured Employer: ______________________ State: ___ Zip:________ Ph: ______________
Relationship to Insured: __________________ Insured DOB: ________ Insured: ◯ Male ◯ Female

Secondary Insurance:_____________________ Insured Name:__________________________
Group#_________________________ Address:_______________________City:________
Insured Employer: ______________________ State: ___ Zip:________ Ph: ______________
Relationship to Insured: __________________ Insured DOB: ________ Insured: ◯ Male ◯ Female

Have you had any physical therapy services this year? ____ If yes, how many sessions? ________________

Notice of Privacy: I acknowledge receipt of Notice of Privacy Practices. I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: ______________________ Witness Signature: ______________________

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages for physical therapy based on your contract with them, not our office. It is your responsibility to know you insurance coverage and benefits as well as the deductible, co-insurance, and any other balances not paid by your insurance. We will assist you in receiving reimbursement; however, you are solely responsible for the remainder of any balances not paid by insurance.

You will be sent monthly statements, which will reflect any payments made by your insurance company on your behalf. Patient statements will be sent to the address given on page one. It is imperative that our office is notified of any address changes for either yourself or your insurance company so that proper follow up and collection efforts may be complete in a timely manner. Patients are responsible for any remaining balance on your account after 60 days from the date of service which has not been paid by your insurance company.

Specific time has been dedicated to your individualized care at Back In Motion Physical Therapy. I understand that my appointment time has been reserved and prepared for me. If I cancel more than 48 business hours in advance, I will not be charged. I understand that if I cancel less than 48 business hours in advance or fail to come to a scheduled appointment, I will be charged an automatic cancellation fee of $125 per visit. Cancellation Fee will need to be paid prior to scheduling any future appointments.

I agree to be financially responsible for all charges. I have read and understand the above policies.

____

Patient Signature/Date

To Our Medicare Patients:

It is a requirement of Medicare that your physician/NNP review, date and sign a Plan of Care written by your physical therapist every 30 to 90 days to complete certification for your initial and continued therapy.

__________initial

Assignment of Benefits:

I hereby authorize payment directly to Back In Motion Physical Therapy for physical therapy benefits otherwise payable to me for services rendered.

__________initial

Authorization To Release Information:

I hereby authorize Back In Motion Physical Therapy to release any information required by my insurance company to process claims.

Patient Name (Print): ______________________________ Date: ______________

Patient Signature: ______________________________

Rhonda Fiorillo, MPT, WCS, PRPC
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Patient History / Initial Evaluation Intake

Name: ______________________ DOB: ____________ Age: ______ Date: ____________

1. Describe the current problem that brought you here. ______________________

____

2. When did your problem first begin? ______________________

3. Was your first episode of the problem related to a specific incident? ◯ Yes ◯ No

Please describe and specify date : ______________________

4. Since that time is it: ◯ staying the same ◯ getting worse ◯ getting better

Why or how? ______________________

5. If pain is present, rate pain on a 0-10 scale with zero being no pain and 10 being the worst. ____________

6. Describe the nature of the pain (i.e. constant burning, intermittent ache): ______________________

7. Describe previous treatment/exercises for this specific issue: ______________________

8. Activities/events that cause or aggravate your symptoms. *Please check all that apply.*

- ◯ Sitting greater than minutes
- ◯ With cough/sneeze/straining
- ◯ Walking greater than minutes
- ◯ With laughing/yelling
- ◯ Standing greater than minutes
- ◯ With lifting/bending
- ◯ Changing positions (ie. -sit to stand)
- ◯ With cold weather
- ◯ Light activity (light housework)
- ◯ With triggers i.e. /key in door
- ◯ Vigorous activity/exercise (run/weight lift/jump)
- ◯ With nervousness/anxiety
- ◯ Sexual activity
- ◯ No activity affects the problem
- ◯ Other, please list ______________________

____

9. What relieves your symptoms? ______________________

10. How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities),specify ______________________

Diet /Fluid intake,specify ______________________

Physical activity, specify ______________________

Work, specify ______________________

Other ______________________

Name: ______________________ DOB: ____________ Age: ______ Date: ____________

Patient History / Initial Evaluation Intake - Page 2

Since the onset of your current symptoms have you had:

- ◯ Fever/Chills
- ◯ Malaise (unexplained tiredness)
- ◯ Unexplained weight change
- ◯ Unexplained muscle weakness
- ◯ Dizziness or fainting
- ◯ Night pain / sweats
- ◯ Change in bowel or bladder functions
- ◯ Numbness / Tingling
- ◯ Other / Describe ______________________

Date of Last Physical Exam: ____________ Tests performed: ______________________

General Health: ◯ Excellent Good ◯ Average ◯ Fair ◯ Poor

Occupation: ______________________ Hours/week: ________ On disability or leave? ◯ Yes ◯ No

Activity Restrictions? ______________________

Activity / Exercise: ◯ None ◯ 1-2 days/week ◯ 3-4 days/week ◯ 5+ days/week

Describe: ______________________

Mental Health: Current level of stress: ◯ High ◯ Med ◯ Low

Current psych therapy? ◯ Yes ◯ No

Have you ever had any of the following conditions or diagnoses? *Check all that apply*

- ◯ Cancer
- ◯ Stroke
- ◯ Emphysema / chronic bronchitis
- ◯ Heart problems
- ◯ Epilepsy / seizures
- ◯ Asthma
- ◯ High Blood Pressure
- ◯ Multiple sclerosis
- ◯ Allergies - please list in "Other"
- ◯ Ankle swelling
- ◯ Head Injury
- ◯ Latex sensitivity
- ◯ Anemia
- ◯ Osteoporosis
- ◯ Hypothyroid / Hyperthyroid
- ◯ Low back pain
- ◯ Chronic Fatigue Syndrome
- ◯ Headaches
- ◯ Sacroiliac / Tailbone pain
- ◯ Fibromyalgia
- ◯ Diabetes
- ◯ Alcoholism / Drug problem
- ◯ Arthritic conditions
- ◯ Kidney disease
- ◯ Childhood bladder problems
- ◯ Stress fracture
- ◯ Irritable Bowel Syndrome
- ◯ Depression
- ◯ Acid Reflux / Belching
- ◯ Hepatitis
- ◯ Anorexia / bulimia
- ◯ Joint Replacement
- ◯ Sexually transmitted disease
- ◯ Smoking history
- ◯ Bone Fracture
- ◯ Physical or Sexual abuse
- ◯ Vision / Eye Problems
- ◯ Sports Injuries
- ◯ Raynaud's (cold hands and feet)
- ◯ Hearing loss / problems
- ◯ TMJ/ neck pain
- ◯ Pelvic pain
- ◯ Other / Describe: ______________________

Name: ______________________ DOB: ____________ Age: ______ Date: ____________

Surgical /Procedure History *Check all that apply*

- ◯ Surgery for your back / spine
- ◯ Surgery for your bladder / prostate
- ◯ Surgery for your brain
- ◯ Surgery for your bones / joints
- ◯ Surgery for your female organs
- ◯ Surgery for your abdominal organs

Other/describe: ______________________

Ob/Gyn History *(females only) Check all that apply*

- ◯ Childbirth vaginal deliveries # ____________
- ◯ Vaginal dryness
- ◯ Episiotomy # ____________
- ◯ Painful periods
- ◯ C-Section # ____________
- ◯ Menopause - when? ____________
- ◯ Difficult childbirth # ____________
- ◯ Painful vaginal penetration
- ◯ Prolapse or organ falling out
- ◯ Pelvic / genital pain

Other/describe: ______________________

Males only: *Check all that apply*

- ◯ Prostate disorders
- ◯ Erectile dysfunction
- ◯ Shy bladder
- ◯ Painful ejaculation
- ◯ Pelvic / genital pain location
- ◯ Other / Describe: ______________________

Medications *(Pills, injections, patch):* ______________________ Start date ____________

Reason for Taking: ______________________

Over the counter vitamins, etc: ______________________ Start date ____________

Reason for Taking: ______________________

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Symptoms *Check all that apply*

- ◯ Trouble initiating urine stream
- ◯ Blood in stool / feces
- ◯ Urinary intermittent / slow stream
- ◯ Painful bowel movements (BM)
- ◯ Strain or push to empty bladder
- ◯ Trouble feeling bowel urge / fullness
- ◯ Difficulty stopping the urine stream
- ◯ Seepage / loss of BM without awareness
- ◯ Trouble emptying bladder completely
- ◯ Trouble controlling bowel urge
- ◯ Blood in urine
- ◯ Trouble holding back gas / feces
- ◯ Dribbling after urination
- ◯ Trouble emptying bowel completely
- ◯ Constant urine leakage
- ◯ Need to support / touch to complete BM
- ◯ Trouble feeling bladder urge / fullness
- ◯ Staining of underwear after BM
- ◯ Recurrent bladder infections
- ◯ Constipation / straining ______% of time
- ◯ Painful urination
- ◯ Current laxative use? Type: ______________________
- ◯ Other / describe: ______________________

Name: ______________________________ DOB: ______________ Age: ______ Date: ______________

Patient History / Initial Evaluation Intake - Page 4

Describe typical position for emptying: ____

1. Frequency of urination: Awake hour's: _____ Times per day:_____ Sleep hours_____ times / night _____
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   _____ minutes, _____ hours, _____ not at all
3. The usual amount of urine passed is: ◯ small ◯ medium ◯ large
4. Frequency of bowel movements times per day, times per week, or month: ______________________
5. The bowel movements typically are: ◯ watery ◯ loose ◯ formed ◯ pellets ◯ other __________
6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
   ◯ minutes ◯ hours ◯ not at all
7. If constipation is present describe management techniques ______________________________
8. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
   Of this total how many glasses are caffienated? ______ glasses per day.
9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness / pressure:
   - ◯ None present
   - ◯ Times per month (specify if related to activity or your menstrual period)
   - ◯ With standing for minutes or hours.
   - ◯ With exertion or straining
   - ◯ Other

10a. Bladder leakage -number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

10b. Bowel leakage -number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

11a. On average, how much urine do you leak?

___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

11b. How much stool do you lose?

___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying
___ Other

12. What form of protection do you wear? *(Please complete only one)*

___ None
___ Minimal protection (tissue paper/paper towel/pantishields)
___ Moderate protection (absorbent product, maxi pad)
___ Maximum protection (specialty product/diaper)
___ Other

On average, how many pad/protection changes are required in 24 hours? _____ # of pads

CONDITIONS & CONSENT FOR PHYSICAL THERAPY *(Please initial)*

______ I understand that I am a patient of Rhonda Fiorillo, MPT, WCS, PRPC at Back In Motion Physical Therapy, at 10789 Double R Blvd, Suite 100, Reno, NV 89521.

______ **Cooperation with treatment:** I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

______ **Cancellation Policy** I understand that if I cancel more than 48 hours in advance, I will not be charged. I understand that if I cancel less than 48 hours in advance or fail to come to a scheduled appointment, I will pay a cancellation fee of $110/Visit. Initial Evaluation will cost $160.

______ **No warranty:** I understand that Back In Motion Physical Therapy and Rhonda Fiorillo, MPT, WCS, PRPC cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that Rhonda Fiorillo,PT, MPT will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:
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 visit concerning the treatment and options available for my condition.

______ **Potential risks:** I understand 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 physical therapist.

______ **Potential benefits** may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

______ **Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Financial and insurance responsibilities:
______ I agree to pay for my evaluation and treatments at the time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made in advance. I understand it is my responsibility to call my insurance company ahead of time and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will provide me with a receipt that is my responsibility to submit to my insurance company. I understand it is my responsibility to fully understand my insurance benefits and that I am ultimately financially responsible for all charges incurred for treatment and supplies pertaining to my treatment received at Back In Motion Physical Therapy.

I have read the above information, and I consent to physical therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Print Name: ______________________________ Date: ________________

Patient's signature ______________________________

Therapist Signature/ Date: ______________________________

Please Save This Form to your computer and click on the below email to send to: sabine@backinmotion.net