PATIENT INFORMATION

Tina L Baum Physical Therapy

Patient Name (Last)	**(First)**	**(MI)**		**Home Phone** ( ) -
Date of Birth / /	**Sex** Male Female	**SSN** - -		**Cellular Phone** ( ) -
Age	**Marital Status** Single Married Widowed Separated Divorced			**Email Address**
Mailing Address		**City**	**State Zip**	**Code**
Physical Address (If different than above)		**City**	**State Zip**	**Code**

Referring Physician	**How Did You Hear About Our Office?** Physician Referral Patient Internet Yellow Pages Other _____
Type of Injury ☐ Work Related ☐ Auto Related ☐ Other	
Date of Injury / Onset / / **Date of Surgery** / /	**Reason for Visit**

Patient's Employer	**Occupation Work**	**Phone** ( ) -	
Employer's Address	**City**	**State**	**Zip Code**

Emergency Contact	**Relationship**	**Address/City/State/Zip**	**Phone** ( ) -

Spouse Information

Spouse's Name (Last)	**(First)**	**(MI)**	**SSN** - -	**Date of Birth** / /
Address	**City**	**State**	**Zip Code**	**Home Phone** ( ) -

Insurance Information

Primary Insurance Company	**Phone**	**Member/Policy ID number**	**SSN** - -
Secondary Insurance Company	**Phone**		**SSN** - -

Attorney Information

Attorney Name	**Attorney's Address /Zip Code /Phone Number**

- **I hereby certify that all information provided is accurate and complete to the best of my knowledge.**

_____ _____ _____

Patient /Responsible Party Signature **Date** **Relationship to Patient**

FINANCIAL AGREEMENT

Tina L Baum Physical Therapy

Thank you for choosing our office as your Physical Therapy provider. Our primary mission is to provide quality of care to our patients. Your clear understanding of this form is important to our professional relationship. Please carefully review and sign this form. If you have any questions about our fees, and/or your responsibilities, please feel free to ask. These policies are subject to change with or without notice.

Insurance:

It is your responsibility to provide us with current insurance information. Please be aware that any amounts not covered by your insurance will be your responsibility. Our office uses a billing service to collect from your insurance; any billing statements received will come from a company called Bottomline Billing. Any failure to pay deductibles and/or co-payments may result in your account being placed with a collection agency.

Appointment Policy:

- **ALL FAILED APPOINTMENTS WILL BE ASSESED A CHARGE OF $50.00.**

Your appointment time will be customized to your present condition. We will not overbook appointments and waiting times should be minimal. Unfortunately, this system may compromise flexibility but will optimize your time, money and good health. Quality treatments for everyone, is based on timely arrival for appointments. There are many circumstances that may arise, on our behalf and yours, that may interrupt the flow of patient care. Please, as a courtesy to others and for your good health, arrive for appointments 10-15 minutes in advance. No call no show, cancellation without at least 24 hours notice and arriving more than 15 minutes late to be seen are all failed appointments. Failed appointment fees are the responsibility of the patient and must be paid in full prior to the next appointment. We have an answering system for which to leave messages after business hours.

Referrals:

If your insurance plan requires you to have a referral to be seen in our office, it is your responsibility to obtain one from your primary care physician and ensure our office has a current copy. If you are seen as a patient and later realize that a referral was needed and not obtained, you will be responsible for the total claim if denied by your insurance.

Minors:

The parent/guardian of the minor that has insurance coverage through will receive billing statements for the minor and will be responsible for payment on the minor's account.

Billing Fees:

- Billing for co-pays: Tina L Baum Physical Therapy expects the patient to pay their co-pay, estimated co-insurance or estimated deductible in full at time of service. If we have to bill you because you do not come prepared to make payment, you will be charged a $25.00 billing fee. If you forget to bring payment, you may leave and return to our office by the end of our business day to avoid this fee.
- Returned checks: There will be a $35.00 fee for any returned check as well as any fees our billing company may issue on your account

Balances:

Any balance on your account must be paid in full prior to your next appointment or you will have to reschedule your appointment to a later time when you are prepared to pay. Our office policy is to make sure there are no debts prior to performing additional services. If your account is currently in collections or on a payment plan, you will not be seen until the account balance is paid in full. Appointment policy will apply.

Assignment Of Payment and Financial Responsibility:

- I request that payment of authorized benefits be made on my behalf to Tina L Baum Physical Therapy for any services furnished to me by my provider. I authorize release of any information needed for processing of the claim to my insurance company. I understand that I am financially responsible for charges not covered by my insurance provider. I also understand that regardless of what my insurance coverage is, I will be financially responsible for all services rendered.
- Tina L. Baum will, as a courtesy to you, submit insurance claims to your insurance carrier. Prior authorizations and verification of insurance coverage will be provided by our office. Please note that verification of benefits and eligibility is not a guarantee of payment.
- Additional charges may be incurred for: interest charges for late payments and collection fees.

_____ _____

Signature (Patient or Authorized Representative) Date

NOTICE OF PRIVACY PRACTICES
Tina L Baum Physical Therapy

Acknowledgement of Notice of Privacy Practices:

The notice of Privacy Practices tells you how we may use and share your health records. Please read it.

- We will use and share your health records to treat you and to bill for services we provide
- We will use and share your health records as required by law

All of the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records

- You have the right to look at and receive a copy of your health records
- You have the right to receive a list of whom we have given your health record to
- You have the right to ask us to correct a mistake in your health record
- You have the right to ask we do not use or share your health record
- You have the right to ask us to change the way we contact you

All of these rights are explained in more detail in the Notice of Privacy Practices.

I understand that the above is a summary of Tina L Baum Physical Therapy Notice of Privacy Practices and I may request a copy.

_____ _____

Signature (Patient or Authorized Representative) Date

Consent to Use and Share Health Record:

I consent to the use and sharing of my health record for treatment, payment, and healthcare operation purposes as described to me in the Notice of Privacy Practices. I understand that if I do not consent, Tina L Baum physical Therapy cannot provide services to me.

_____ _____

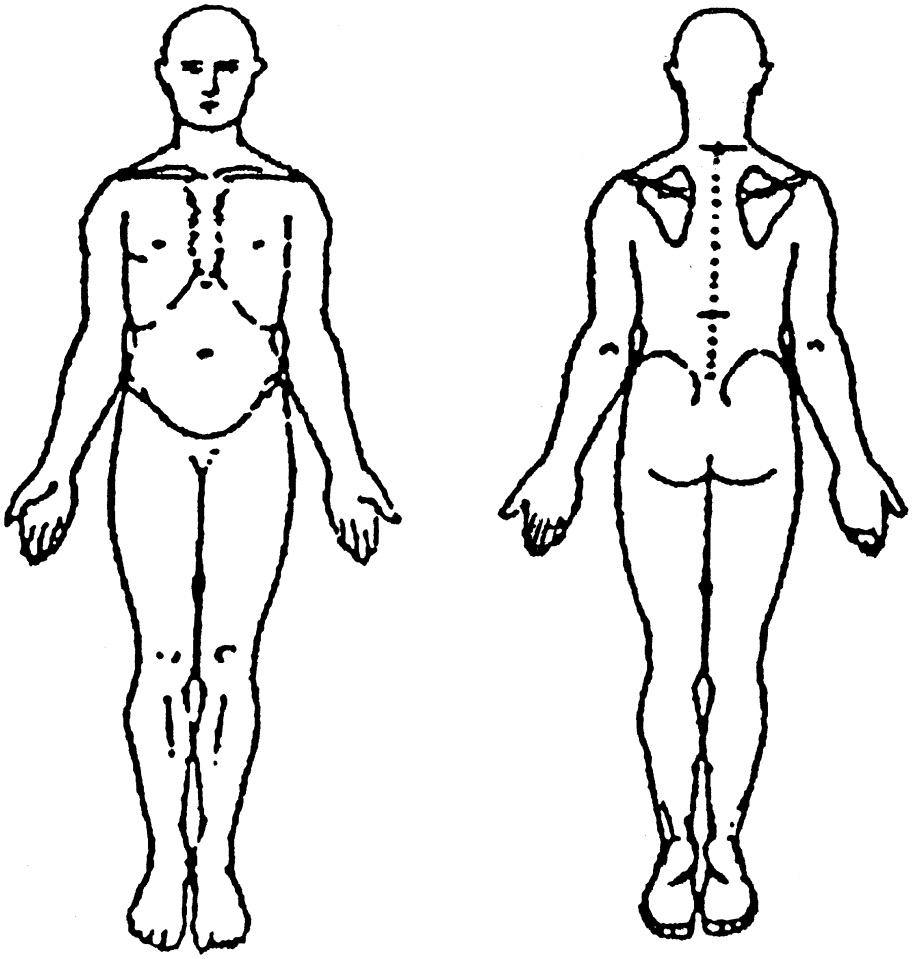
Signature (Patient or Authorized Representative) Date

Using the scale below, please indicate the number which best represents the severity of your pain.

Average for the last 48 hours **_____ out of 10** _____
Best for the last 48 hours **_____ out of 10** _____
Worst for the last 48 hours **_____ out of 10** _____

0	Pain Free
1	Very minor annoyance - occasional minor twinges.
2	Minor annoyance - occasional strong twinges.
3	Annoying enough to be distracting.
4	Can be ignored if you are really involved in your work, but still distracting.
5	Can't be ignored for more than 30 minutes.
6	Can't be ignored for any length of time, but you can still go to work and participate in social activities.
7	Makes it difficult to concentrate, interferes with sleep. You can still function with effort.
8	Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.
9	Unable to speak. Crying out or moaning uncontrollably - near delirium.
10	Unconscious. Pain makes you pass out.

On the body map below, please indicate where you feel the following symptoms:
X pain 0 numbness / burning -> shooting pain



Medical Screening Questionnaire

Answering the following questions will help us to manage your care better. Some of the questions may seem like they do not apply to your condition, but your activities of daily life affect your rehabilitation. Please complete all pages prior to your appointment. If you need additional room, please use the last page of this form or the back. Thank you.

Name:_____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight:_____Date of last doctor visit: _____

What is your primary concern for today's visit?_____

Special tests doctor has performed for your condition: _____

Do you now have or have you had a history of the following? Explain checked responses and include dates.

Medical History

- ☐ Cancer—Type _____
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibulator
- ☐ Stroke
- ☐ Circulation Problems (CVI/Blood Clots)
- ☐ Asthma
- ☐ Emphysema/Bronchitis
- ☐ Smoking habit
- ☐ Chemical dependency (alcohol,drugs)
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Other arthritic conditions
- ☐ Depression
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Kidney disease
- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Epilepsy
- ☐ Allergies
- ☐ Allergic to Latex
- ☐ Low back pain/sciatica
- ☐ Joint Problems
- ☐ Broken Bones
- ☐ Sexually transmitted diseases
- ☐ Pelvic pain
- ☐ Abdominal Pain
- ☐ Pelvic Trauma

Have you recently noted:

- ☐ Weight Loss/gain
- ☐ Nausea/vomiting
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever/chills/sweats
- ☐ Numbness or tingling

Explanations of above checked responses _____

_____

_____

During the past month have you been feeling down, depressed or hopeless? ☐ YES ☐ NO

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ YES ☐ NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ YES ☐ NO

Medications

Which of the following **OVER-THE-COUNTER** medications have you taken in the last week?

- ☐ Aspirin
- ☐ Tylenol
- ☐ Advil/Motrin/Ibuprofen
- ☐ Laxatives
- ☐ Decongestants
- ☐ Antihistamines
- ☐ Antacid
- ☐ Vitamins/Mineral supplements
- ☐ Other _____

List any **PRESCRIPTION** medication you are currently taking (including pills, injections and/or skin patches):

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

How much caffeinated coffee or caffeine containing beverages do you drink per day?_____

How many packs of cigarettes do you smoke a day? _____ How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting?_____

Surgical History

- ☐ Surgery for your back/spine
- ☐ Surgery for your brain
- ☐ Other type please describe_____
- ☐ Surgery for your female organs
- ☐ Surgery for abdominal organs
- ☐ Surgery for bladder
- ☐ Surgery for Prostate

Explanations of above checked responses _____

_____

_____

Medical Screening Questionnaire

Name: _____

Urologic History

- ☐ Trouble initiating urine stream
- ☐ Trouble emptying bladder
- ☐ Excessive Urges to empty bladder
- ☐ Trouble feeling bladder fullness
- ☐ Constant dribbling of urine
- ☐ Frequent urination
- ☐ Pain with urination
- ☐ Incontinence
- ☐ Childhood bladder problem
- ☐ Bed wetting
- ☐ Blood in urine
- ☐ Bladder Infections
- ☐ Vaginal dryness
- ☐ Bladder cancer

Explanations of above checked responses _____

_____

_____

Sexual History

- ☐ Sexually active
- ☐ Does your sexual activity cause you pain?

Explanations of above checked responses _____

_____

_____

Bowel History

- ☐ Irritable bowel syndrome
- ☐ Hemorrhoids
- ☐ Fecal incontinence/leaking
- ☐ GI problems
- ☐ Difficulty eliminating
- ☐ Rectal Pain
- ☐ Constipation
- ☐ Trouble holding back gas

OB/Gyn History (Female only)

- ☐ Painful periods
- ☐ Date last period _____
- ☐ Endometriosis
- ☐ Cysts
- ☐ Menopause
- ☐ Prolapse or falling out feeling
- ☐ Painful penetration
- ☐ Upon entry
- ☐ Deep
- ☐ Positional
- ☐ Are You Pregnant? _____ weeks
- ☐ Vaginal deliveries #_____
- ☐ Episiotomy #_____
- ☐ C-Section #_____
- ☐ Difficult childbirth

Explanations of above checked responses _____

_____

_____

Relevant History (Male Only)

- ☐ Prostatitis
- ☐ Penile Pain
- ☐ Scrotum Pain
- ☐ Rectal Pain
- ☐ Surgery
- ☐ Pain with ejaculation

Explanations of above checked responses _____

_____

_____

Please list any other concerns or comments you have:

_____

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Reviewed by therapist: **Tina** _____ _____ _____

Therapist Signature Date

Symptom Questionnaire

Name: _____ DOB: ___/___/____
Describe the reason for your appointment: _____
When did this problem begin? _____ Is it getting better? _____ worse? _____staying the same? _____
List activities or things that you cannot do because of this problem:_____

Bladder leakage frequency – number (#) of episodes
- ☐ Never
- ☐ Only with strong cough/sneeze
- ☐ Only premenstrual
  - ___ # per month
  - ___ # per week
  - ___ # per day

Severity of leakage (Check one)
- ☐ No leakage
- ☐ Few drops
- ☐ Wets underwear
- ☐ Wets outerwear

Protection worn (Check One)
- ☐ None
- ☐ Tissue paper / paper towel
- ☐ Pantishields
- ☐ Minipads
- ☐ Maxipads
- ☐ Specialty product name _____
- ☐ Diaper

Leakage caused or increased by (Check all that apply)
- ☐ Vigorous activity or exercise (running, weight lifting)
- ☐ Light activity (walking, light housework)
- ☐ Changing positions (sit to stand)
- ☐ Walking to the toilet
- ☐ Strong urge to go
- ☐ Intercourse or sexual activity
- ☐ No activity changes leakage (constant despite activity)
- ☐ Other, please list _____

Position or activity with leakage. (Check all that apply)
- ☐ Lying down
- ☐ Sitting
- ☐ Standing

How long can you delay the need to urinate? (check one)
- ☐ Not at all
- ☐ 1-2 minutes
- ☐ 3-10 minutes
- ☐ 11-30 minutes
- ☐ 31-60 minutes
- ____ hours

Rate feeling of "falling out" or pelvic heaviness/pressure
- ☐ None present
- ____ times per month
- ☐ Only with menstruation
- ☐ standing
- ☐ With exertion or straining
- ☐ At the end of each day
- ☐ Present all day

Fluid intake (one glass is 8 oz or one cup)
- ____ glasses per day
- # of caffeinated glasses ____per day
- # of alcoholic beverages ____per day

Rate your feeling as to the severity of this problem from 0-10 with 10 being the worst
0--- ----------10
Not a problem Major problem

Rate the following statement as it applies to you today. **My bladder is controlling my life.**
0--- ----------10
Not true at all Completely true

Bladder Habits

How often do you urinate during the day? ____# of times
How often do you urinate after going to bed? ____ # of times
Do you take your time to go to the toilet and empty your bladder? ☐Yes☐No
Number of bladder infection in the last year?____
Can you stop the flow of urine when on the toilet? ☐Yes☐No
Is the volume of urine passed usually; ☐Large ☐Average ☐Small ☐Very Small
Do you have the sensation that you need to go to the toilet? ☐Yes☐No
Do you strain to pass urine? ☐Yes☐No
Do you empty your bladder frequently, before your experience the urge to pass urine? ☐Yes☐No
Do you have the feeling you bladder is still full after urinating? ☐Yes☐No
Do you have a slow or hesitant urinary stream? ☐Yes☐No
Do you have difficulty initiating the urine stream? ☐Yes☐No
Do you have "triggers" that make you feel like you can't wait to go to the toilet (running water, etc)? ☐Yes☐No
Please list _____

Bowel Habits

Frequency of bowel movements ____ per day ____ per week
Consistency of stool ☐loose ☐ normal ☐ hard
History of constipation? ☐Yes☐No
Do you currently strain to go? ☐Yes☐No
Do you ignore the urge to defecate? ☐Yes☐No
Do you have trouble making it to the toilet on time when you have an urge to go? ☐Yes☐No

Tina L. Baum
Physical Therapy
2880 N Tenaya Way., Suite 405 · Las Vegas, Nevada
89128 Office 702.877.2000 · Fax 702.877.2100

GENERAL CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred to Tina L. Baum Physical Therapy for evaluation and treatment of Pelvic Floor Dysfunction. I understand that to evaluate my condition it may be necessary, initially and periodically, to have my physical therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length. Such evaluation and treatment may include, but not be limited to, the following: observation, palpation, use of internal/external sensors for biofeedback and or electrical stimulation, exercise, soft tissue mobilization, education, instruction and neuromuscular techniques of the perineal area. Treatment may also include joint mobilization and modalities such as ultrasound and electrical stimulation to the perineal area and other associated areas (abdominal area, hips, back, etc.)

I understand that no guarantees have been or can be provided regarding the success of therapy. I hereby request and consent to the evaluation and treatment to be provided by the physical therapists of Tina L. Baum Physical Therapy.

_____ _____ _____
Patient Name (Please Print) Signature Date

_____
Witness