Metamora
Physical Therapy

Date _____

Name: (First)_____ (Last)_____ (Middle) _____ Birth Date_____

Address: _____ Apt #/PO Box # _____

City _____ State _____ Zip_____

Day Phone _____ Home Phone _____ Cell Phone_____

*If you **do not** want to receive appointment reminders, please check ☐

E-Mail _____
(For appointment reminders, updates, seminars, event notices)

Marital Status: ___Married ___Single ___Other Sex: ___Male ___Female

Former Patient: ___Yes ___No

How did you hear of Metamora Physical Therapy? _____

Are you currently receiving any home care services? (PT, OT, Nursing, Speech) ___Yes ___No

Have you had home care services this year? (PT, OT, Speech) ___Yes ___No

Referring Physician:_____

If you would like us to send copies of correspondence to your primary care physician, please complete:

Primary Care Physician: _____ Phone:_____

PATIENT INFORMATION

Current employment/school information: _____

AUTO

Is this an Auto Accident? ___Yes ___No If yes, please complete the following:

Date of accident:_____ In what city and state did the accident occur?: _____

Is this a Lawsuit? ___Yes ___No Law firm name: _____

Attorney Name: _____ Attorney Phone: _____

WORKER'S COMPENSATION

Is this a worker's compensation claim? ___Yes ___No If yes, please complete the following:

Employers Name: _____ Employers Phone#: _____

City/State:_____ Job Title:_____

Is this an approved Worker's Comp Injury? ___Yes ___No

Date of Injury: _____ In what city and state did the injury occur? _____

Law Firm Name: _____

Attorney Name: _____ Attorney Phone: _____

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Patient Name:_____ Date:_____

Please list any medications, vitamins, or supplements you are currently taking:

Medication	Dosage	Frequency

Please list any allergies you have:

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Patient name:_____ Date: _____

Please check all that apply to you:

o	Cancer or Malignancy	o	Diabetes
o	Heart Condition	o	High Blood Pressure
o	Alzheimer's/Dementia	o	Lupus/Rheumatoid Arthritis
o	Fibromyalgia	o	Ulcer or digestive disorder
o	Gout	o	Respiratory Disorder
o	Chronic Fatigue	o	Pain with Sex
o	Difficulty swallowing	o	Stroke
o	Pacemaker/Defibrillator	o	Metal implants
o	Osteoporosis	o	Seizures
o	Dizziness/faintness/vertigo	o	COPD
o	Currently Pregnant	o	Infectious disease
o	Constipation or diarrhea	o	Urinary or bowel incontinence
o	Neurological condition (MS/Parkinson's)	o	Fractures
o	Anemia	o	Arthritis
o	ADHD	o	TMJ
o	Psychological disorder	o	Anxiety and/or depression
o	Thyroid Condition	o	HIV/AIDS
o	Sleep disorder	o	Asthma
o	Digestive issues	o	Eating disorder
o	Headache/migraines	o	Allergies

If yes to any of the above, please describe:

_____

_____

_____

Please list any operations, serious illnesses, accidents, or broken bones that you've had from birth to present:

_____

_____

_____

Do you smoke? ___Yes ___No If yes, what do you smoke? _____

Have you gained or lost weight in the past 12 months? ___Yes ___No

During the past month, have you been feeling down, depressed or feeling hopeless? ___ Yes ___No

During the past month have you experienced little interest or pleasure in doing things? ___Yes ___No

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Treatment received so far for this diagnosis:

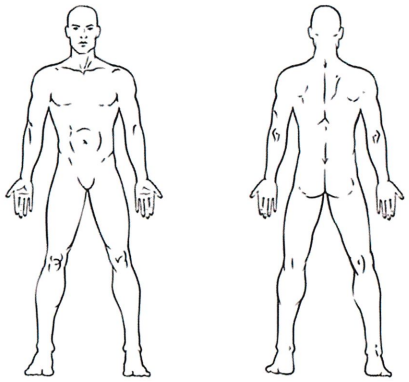
___Physical/Occupational Therapy ___Injections ___Massage ___Chiropractic ___Acupuncture

Other:_____

Have you received physical/occupational therapy in the past year? ___Yes ___No

Have you had testing done for this diagnosis? ___X-Ray ___CT Scan ___MRI ___Bone Scan

Please mark the following diagrams/scales as they describe your pain level and function **today**:



No Pain Most Pain

0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms better? _____

What makes your symptoms worse? _____

What time of day are your symptoms worse? ___Morning ___Afternoon ___Evening ___Overnight

What are your goals for therapy? _____

Additional comments and/or information you would like to add?

_____

_____

Date of next physician appointment: _____

I certify that I have answered the questions on this form accurately and honestly. I understand that providing incorrect information can be harmful to my physical therapy treatment. I understand that it is my responsibility to inform my Physical Therapist of any changes in my medical status.

_____ _____

Printed name of Patient Date

_____ _____

Signature of Patient/Parent/Guardian Printed name of parent/guardian

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Name:	Birth Date:
Are you currently working outside the home?	Occupation:

Please describe your symptoms and explain why you are here today:
Do you have a medical diagnosis? (Ex. Prolapse, incontinence, interstitial cystitis, etc.)
Have you had any previous treatment for this diagnosis?
Have you had any testing done related to this diagnosis?

How much stress do you experience? ___None ___Low ___Medium ___High
What do you do to reduce stress?
Do you exercise? ___Yes ___No If yes, what do you do? How often do you work out?
How many hours of sleep do you get at night? Any difficulty falling asleep? ___Yes ___No
How many hours of screen time do you get a day? (Computer, cell phone, TV, etc.)
How would you describe your diet? ___Good ___Poor ___Bad Do you eat fruits and vegetables? ___Yes ___No
How many caffeinated beverages do you consume per day?

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How many cups of water do you consume per day?

Do you have a safe support system? ___Yes ___No
Comments:

Do you have a history of sexual or physical trauma? ___Yes ___No
Comments:

In order to get rid of your symptoms, how willing are you to commit to change?

___Whatever it takes ___Significant change ___Some change ___No change

Are there any other comments/concerns you have at this time?

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Bowel function

How often do you usually have a bowel movement?	Every other day	Daily or multiple times a day	Less than every 3 days	Less than once a week
What is the consistency of your stool?	Soft	Hard/pebbles	Watery/loose	Firm
Do you have to strain a lot to empty your bowels?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you use laxatives?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you ever feel constipated?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you experience uncontrollable gas?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you have urgency to empty your bowels?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you ever leak watery stool?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you ever leak normal stool?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you ever have a feeling of incomplete bowel emptying?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily

Sexual function

Are you sexually active?	No	Less than once per week	More than once per week	Daily or most days
If you're not sexually active, why?	No partner	Unable	Partner unable	Too painful
Do you have pain with intercourse?	Never	Occasionally	Frequently	Always
Do you leak urine or stool during intercourse?	Never	Occasionally	Frequently	Always
How much do these sexual issues bother you?	Not at all	Slightly	Moderately	Greatly

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Bladder function

How many times do you urinate in a day?	Up to 7 times	Between 8-10 times	Between 11-15 times	More than 15 times
How many times do you get up during the night to urinate?	0-1 time	2 times	3 times	More than 3 times
During then night, do you wet the bed before you wake up?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Always (every night)
Do you rush or hurry to urinate when you get the urge?	Never, I can wait	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you leak urine when you rush or hurry to the toilet?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you leak urine with squatting, sneezing, laughing, or coughing?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Is your urinary stream weak, prolonged, or slow?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you ever have a feeling of incomplete bladder emptying?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you need to strain to empty your bladder?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you have to wear pads because of urinary leakage?	Never	Only as a precaution	Only with activity like exercise	Always
Do you limit your fluid intake in an attempt to decrease leakage?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Do you have frequent bladder infections?	No	1-3 infections per year	4-12 infections per year	More than once a month
Do you have pain when you empty your bladder?	Never	Occasionally (less than once per week)	Frequently (once or more per week)	Daily
Does urinary leakage effect your daily routine?	Not at all	Slightly	Moderately	Greatly

I certify that I have answered the questions on this form accurately and honestly. I understand that providing incorrect information can be harmful to my physical therapy treatment. I understand that it is my responsibility to inform my Physical Therapist of any changes in my medical status.

_____ _____

Printed name of Patient Date

_____ _____

Signature of Patient/Parent/Guardian Printed name of parent/guardian

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PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to:

- Urinary or fecal incontinence
- Difficulty with bowel, bladder, or sexual dysfunctions
- Painful scars after childbirth or surgery
- Persistent sacroiliac or low back pain and pelvic pain conditions

I understand that, in order to evaluate my condition, it may be necessary for my therapist to perform an internal pelvic floor muscle examination (initially and periodically.) I understand this examination is performed by observing and/or palpating the perineal region including the vagina, penis, and/or rectum. This evaluation will assess:

- Skin condition and reflexes
- Muscle tone, length, strength, and endurance
- Scar mobility
- Function of pelvic floor region

Treatment may include, but is not limited to:

- Observation and palpitation
- Use of vaginal weights
- Vaginal or rectal sensors for biofeedback and/or electrical stimulation
- Ultrasound, heat, and/or cold
- Stretching and strengthening exercises
- Soft tissue and/or joint mobilization
- Educational instruction

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

The purpose, risks, and benefits of this evaluation and treatment have been explained to me.
Please check boxes below.

- ☐ I understand that I can terminate the procedure or treatment at any time
- ☐ I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation or treatment
- ☐ I understand that I have the option to having a second person in the room during the internal evaluation and treatment and I will inform my therapist of this if I choose to do so
- ☐ I give my informed consent for a pelvic floor examination and treatment

_____ _____

Printed name of Patient Date

_____ _____

Signature of Patient/Parent/Guardian Printed name of parent/guardian

NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

	Yes	No
a. Area between rectum and testicles (perineum)	❑1	❑0
b. Testicles	❑1	❑0
c. Tip of the penis (not related to urination)	❑1	❑0
d. Below your waist, in your pubic or bladder area	❑1	❑0

2. In the last week, have you experienced:

	Yes	No
a. Pain or burning during urination?	❑1	❑0
b. Pain or discomfort during or after sexual climax (ejaculation)?	❑1	❑0

3. How often have you had pain or discomfort in any of these areas over the last week?

- ❑0 Never
- ❑1 Rarely
- ❑2 Sometimes
- ❑3 Often
- ❑4 Usually
- ❑5 Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

- ❑0 Not at all
- ❑1 Less than 1 time in 5
- ❑2 Less than half the time
- ❑3 About half the time
- ❑4 More than half the time
- ❑5 Almost always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- ❑0 Not at all
- ❑1 Less than 1 time in 5
- ❑2 Less than half the time
- ❑3 About half the time
- ❑4 More than half the time
- ❑5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

- ❑0 None
- ❑1 Only a little
- ❑2 Some
- ❑3 A lot

8. How much did you think about your symptoms, over the last week?

- ❑0 None
- ❑1 Only a little
- ❑2 Some
- ❑3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

- ❑0 Delighted
- ❑1 Pleased
- ❑2 Mostly satisfied
- ❑3 Mixed (about equally satisfied and dissatisfied)
- ❑4 Mostly dissatisfied
- ❑5 Unhappy
- ❑6 Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c,1d, 2a, 2b, 3, and 4 = _____

Urinary Symptoms: Total of items 5 and 6 = _____

Quality of Life Impact: Total of items 7, 8, and 9 = _____

Reprinted with permission from: Litwin MS, McNaughton-Collins M, Floyd J, et al. The National Institutes of Health Chronic Prostatitis Symptom Index: development and validation of a new outcome measure. J Urol. 1999; 162:369-375.

Metamora Physical Therapy

3562 S. Lapeer Rd. Ste F, Metamora, MI 48455 Phone: 810-212-1277 Fax: 810-212-1282

1. CONSENT FOR TREATMENT: I consent to and authorize my physical therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least a 24-hour notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $50.

WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. RESPONSIBILITY FOR PAYMENT: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Metamora PT, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Metamora PT with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. When you provide a check as payment in the clinic, you authorize us to use the information from your check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from your account, or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day and you will not receive your check back from your financial institution.
Please note that refusal to sign this form does not change responsibility for payment in any way.

4. ASSIGNMENT OF BENEFITS: I hereby assign to Metamora PT all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Metamora PT may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Metamora PT's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Metamora PT's Notice of Privacy Practices

and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

6. HIPAA CONSENTS: In compliance with HIPAA regulations, I give consent to the following individuals to receive verbal information regarding the billing and scheduling of my account:

Name/Relationship_____

Name/Relationship _____

Name/Relationship_____

I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

7. CONSENT FOR EMERGENCY CONTACT INFORMATION:

Person to contact in case of an emergency:

Name:_____

Telephone Number:_____ Relationship:_____

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Signature of Patient/Legally Responsible Person:_____

Printed Name of above:_____ Date: _____

Metamora Physical Therapy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Metamora Physical Therapy, LLC
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Metamora Physical Therapy, LLC's LEGAL DUTY

Metamora Physical Therapy, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Metamora Physical Therapy, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Metamora Physical Therapy, LLC may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Metamora Physical Therapy, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Metamora Physical Therapy, LLC 's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Metamora Physical Therapy, LLC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Metamora Physical Therapy, LLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Metamora Physical Therapy, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Metamora Physical Therapy's health information practices or if you have a complaint, please contact the following person:

Metamora Physical Therapy, LLC
Office Administrator
3562 S. Lapeer Rd. Ste F, Metamora, MI 48455
Telephone: 810-212-1277 Fax: 810-212-1282

Metamora Physical Therapy, LLC
PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Metamora Physical Therapy, LLC's Notice of Information Practices. I understand that Metamora Physical Therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ABC PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in Metamora Physical Therapy, LLC's Notice of Information practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

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Physical Therapy

APPOINTMENT ATTENDANCE AGREEMENT

I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks.

I agree to and understand the following:

1. I must provide at least a 24-hour notice when I need to cancel or reschedule an appointment. I understand that a cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $50.00.
2. I understand that three (3) cancelled appointments in a row, regardless of given notice, will result in an automatic discharge from physical therapy.
3. I agree to provide a credit card to remain on file for cancellation/no show charges. **I understand my card will be charged automatically if I no-show an appointment.** (We understand that cancellations will occur due to sickness, scheduling conflicts, emergencies, etc. We will consider appropriate allowances in these circumstances.)

Printed name: _____

Signature: _____

Date: _____