Trinity Health
Probility Physical Therapy

PATIENT REGISTRATION & CONSENT TO TREAT FORM

Last Name	First Name	MI	DOB	Sex	SSN

Address	City/State/Zip	Marital Status

Home Phone #	Cell Phone #	E-mail Address

Employer Name	Employer Phone	Current Position

Employer Address	City/State/Zip

IN CASE OF EMERGENCY

Contact's Full Name	Relationship to Patient	Cell Phone #	Other Phone

(Optional) GUARANTOR

(Guarantor info required if patient is under 18; Please state the name, phone number and address of the person financially responsible for all balances relating to this patient.)

Guarantor Full Name	Address	

City/State/Zip	Guarantor Phone #	Relationship to Patient

CONSENT TO TREAT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO PROBILITY PHYSICAL THERAPY IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS.

A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF PROBILITY PHYSICAL THERAPY AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE. I CONSENT TO BEING KNOWINGLY PHOTOGRAPHED OR VIDEOTAPED BY AUTHORIZED PERSONNEL OF PROBILITY PHYSICAL THERAPY FOR MEDICAL REASONS WHEN NEEDED SUCH AS POSTURAL CORRECTION, GAIT/MOVEMENTANALYSIS OR EDUCATIONAL PURPOSES. FOR REFERENCE THE TRINITY HEALTH NON- DISCRIMINATION POLICY IS POSTED IN EACH CLINIC. A COPY OF THIS NON-DISCRIMINATION POLICY WILL BE PROVIDED UPON REQUEST.

After reviewing the corresponding policies, please initial next to each statement:

_____ I acknowledge that I have read, understand and agree to the **Notice of Patient Information Practices**

Probility may not sell or disclose protected health information to a business associate or any other third party for that party's own marketing purposes.

By signing this form, you authorize Probility to contact you regarding marketing of health-related products and services through email or postal mail.

If you wish to OPT OUT of such marketing materials, please check this box: ☐

_____ I acknowledge that I have read, understand and agree to the **Cancellation/No-Show Policy**

_____ I acknowledge that I have read, understand and agree to the **Notice of Billing Department Policies**

_____ _____

Authorized Signature (parent signature for minors) **Date**

MRN: _____

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PELVIC HEALTH INITIAL PATIENT QUESTIONNAIRE

Name:_____ **Date:** _____

1) What are your symptoms? _____

2) How do your symptoms affect your life? _____

3) Date of injury / onset of symptoms: _____

4) Which of the following best describes how your symptoms occurred? (Check only one):

- □ Lifting
- □ Car Accident
- □ A Fall
- □ Exercise
- □ Trauma
- □ Pregnancy / Delivery
- □ During Recreation / Sports
- □ Surgery
- □ Cumulative / Overuse
- □ Unknown
- □ Childhood
- □ Other: _____

5) Since the onset of symptoms is it: □ Staying the same □ Getting worse □ Getting better

6) Are you currently lactating? (Check all that apply) □ Breastfeeding □ Pumping □ Does not apply

7) Are you currently pregnant? □ Yes □ No Due Date: _____

8) Medical History

- □ Vaginal Deliveries #_____
- □ Vaginal Tearing # _____
- □ Pregnancy # _____
- □ C-Section # _____
- □ Menopause – When? _____
- □ Painful Intercourse
- □ Pelvic Pressure
- □ Shy Bladder
- □ Other: _____
- □ Erectile Dysfunction
- □ Painful Ejaculation
- □ Prostate Disorders

9) Surgical History

Have you ever had any operations on the abdomen, back, pelvis, or hip?

□ No □ Yes, date: _____ □ Procedure / Treatment: _____

10) Please complete the urinary and bowel health questions below:

	Initial Evaluation:
Urinary Frequency during day	
Urinary Frequency during night	
Urinary leakage per day	
Bowel leakage per day	
Bowel Frequency	
Fluid Intake	
Pads / liners per day **Menstrual leakage**	
Bristol Stool Type	

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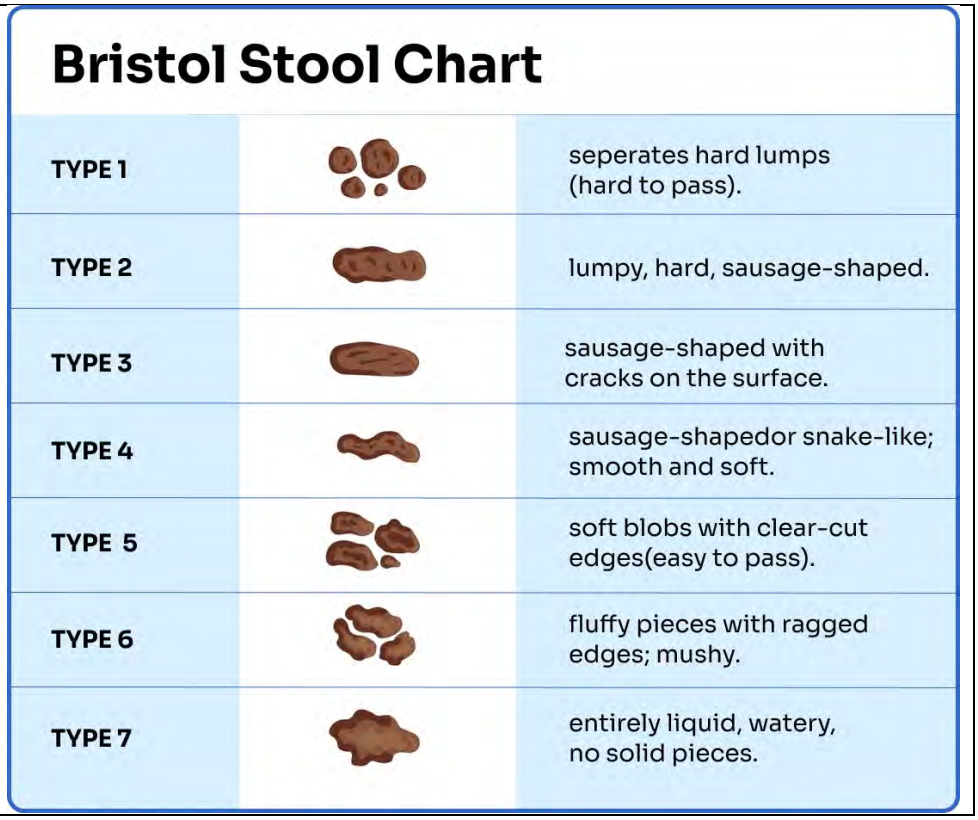
Please indicate what your stool looks like

Select Stool Type Here



11) Nature of symptoms (Check all that apply):

□ Sharp □ Dull □ Aching □ Tingling
□ Occasional □ Constant □ Throbbing □ Other: _____

12) Please state your pain level on a scale of 0-10 (0 = no pain, 10 = hospitalized by pain): ____/10

13) What makes your symptoms worse? (Check all that apply):

□ Sitting >_____ min □ Laying Down □ Urination □ Gynecological Exam
□ Going to/from Sitting □ Lifting / Bending □ Tampons/Menstrual Cup □ Light Activity _____
□ Standing >_____min □ Coughing / Sneezing □ Sustained Bending □ Ejaculation
□ Squatting □ Intercourse □ Bowel Movement □ Lying Down
□ Walking >_____min □ Stress / Anxiety □ Laughing □ Menstrual Cycle
□ Up / Down Stairs □ Taking a deep breath □ Triggers ie: sound of water, turning house key
□ Sports/recreation/heavy activity such as:

_____

14) What relieves / lessens your symptoms?

□ Sitting □ Changing Positions □ Exercise □ Stretching
□ Standing □ Rest □ Heat □ Massage
□ Lying Down □ Alcohol □ Cold □ Nothing
□ Other:_____

15) What previous treatment have you had?

□ Physical Therapy □ Massage Therapy □ Bracing/Taping □ Injections
□ Exercise □ TENS Unit □ None □ Manipulations/Adjustment by an Osteopath or Chiropractor
□ Medication □ Traction □ Other: _____

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16) Have you had any of the following images of the pelvis and/or lower back?

□ X-rays □ MRI □ Defecography □ Urine Dynamics □ Cystoscope □ Sitz Marker Test
□ Urine Test □ Anal Rectal Manometry □ Other: _____

17) How do you spend most of your time?

□ Part-time employment □ Full-time employment □ Restricted duty □Caring for child(ren)
□Other caregiving □Volunteering/community involvement □Other_____
Occupation (specific): _____

18) What positions are you in for the above activities?

□ Standing □ Sitting □ Walking □ Bending □ Lifting:_____lbs._____times a week

19) Please list any activities that you currently can't, have difficulty, or avoid now because of your symptoms: _____

_____

_____

20) What goals would you like to achieve from therapy or how would you like therapy to improve your quality of life? _____

_____

(Please circle the best that applies to you)

General Health: Click Here

Please rate your level of happiness with 10 being the highest level: Click Here

Currently in mental health therapy: □ Yes □ No

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

Who (if any one) lives with you in your home? _____

What activities or roles are most important to you in your day-to-day life?

_____

Any additional information you would like to provide: _____

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Name:_____ **Date:** _____

MEDICATIONS

List medications (including prescribed pills, skin patches, injections, vitamins/supplements and over the counter medicines) you are currently on and their prescribed purpose. Attach list if needed.

If your primary care physician is from an IHA office this section does not need to be completed.

Medication Name	Dosage/Frequency	Prescribed Purpose	Medication Form *Oral, Topical, Inhaled, Injection*
			Type of Medication
			Type of Medication
			Type of Medication
			Type of Medication
			Type of Medication
			Type of Medication
			Type of Medication

MRN: _____
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