

# Atlantic Physical Therapy Center

ATLANTICPTCENTER.COM

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## Referral Information

Past Patient: ☐ YES ☐ NO

Whom may we thank for referring you to us?

## Patient Information

### EMAIL:

(Providing email is consenting to receiving emails from Atlantic Physical Therapy Center)

Patient Name: (First, MI, Last, - Sr., Jr., etc)

Social Security #:

Address:

City

State:

Zip Code:

Please check one box as  
PRIMARY contact number.

☐ Home Phone: ( ) -

☐ Cell Phone: ( ) -

(Providing cell phone is consenting to receive texts. Text and data rates may apply.)

Date of Birth  
(mm-dd-yyyy)

Sex:  
☐ M  
☐ F

Status: ☐ Single ☐ Married  
☐ Divorced ☐ Widowed  
☐ Separated ☐ Unknown

Date of Injury / Onset Date

Auto Related:

☐ Yes - State? \_\_\_\_\_

☐ No

Work Related:

☐ Yes

☐ No

Adjustor Name & Telephone #:

Claim #

If Workers Comp, was accident with present Employer? ☐ Yes ☐ No

If No, who was employer? \_\_\_\_\_

Occupation: \_\_\_\_\_

If Auto Accident, Date of Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Type of Accident: Driver / Passenger /  
Pedestrian / Job / Fall / Other

**Do you have Medicare Insurance Coverage?** ☐ No ☐ Yes Are you receiving Home Health Services? ☐ No ☐ Yes

## Primary Insurance Information (Please DO NOT skip this section)

Name of Insurance Company:

Policy or Claim #:

Group # / Policy Holders Employer:

Policy Holder Name:

Date of Birth:

Policy Holders Phone #:

Policy Holder Address:

**Patient Relationship to Policy Holder:**

☐ Self ☐ Spouse ☐ Dependent ☐ Other

## Secondary Insurance Information (Backup if Auto is Primary)

Name of Insurance Company:

Policy or Claim #:

Group # / Policy Holders Employer:

Policy Holder Name:

Date of Birth:

Policy Holders Phone #:

Policy Holder Address:

**Patient Relationship to Policy Holder:**

☐ Self ☐ Spouse ☐ Dependent ☐ Other

## Employer Information

Employer Name:

Employer Phone #:

Employment Status: ☐ None

☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student

Address:

City

State:

Zip Code:

## Emergency Contact Information

Contact Name:

Phone #

Relationship to Patient:

☐ Parent ☐ Spouse ☐ Sibling ☐ Child ☐ Other

## Financial Policy

As the patient, you are responsible for knowing the policies and procedures of your insurance plan, including pre-certification requirements, limitations, maximum benefits, co-payments, etc. As a courtesy, we will submit all primary and secondary insurance billing. Any remaining balance such as co-insurance, deductible, etc. is your responsibility. If you have any questions, please speak to a member of our office staff.

I \_\_\_\_\_ authorize Atlantic Physical Therapy Center to treat me as per my doctor's prescription and to release to my insurance company/Employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

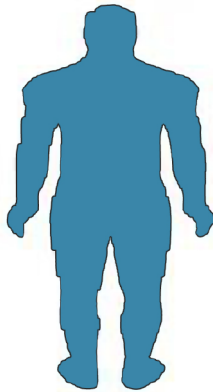
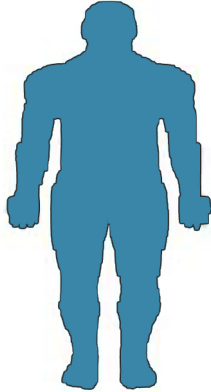
## Atlantic Physical Therapy Center Pain Profile

1. What activities increase your problem: \_\_\_\_\_
2. What activities decrease your problem: \_\_\_\_\_
3. Are you presently working?    Yes ☐    No ☐    Occupation: \_\_\_\_\_
4. What do you hope to accomplish with PT? \_\_\_\_\_
5. **REQUIRED BY INSURANCE** – Please provide us your Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please shade/circle in the areas that correspond to your pain or numbness

**FRONT**

**BACK**



**Please Rate Pain**

(0 = none; 10 = worst)

0  
1  
2  
3  
4  
5  
6  
7  
8  
9  
10

### Injury Information

Work Related Injury    Athletic Injury    Motor Vehicle Accident    Other: \_\_\_\_\_  
Date of Injury / Surgery \_\_\_\_\_ Date of next doctor's visit \_\_\_\_\_

Have you ever had these symptoms before? \_\_\_\_\_

Please check any of the following that apply to you:

- |   |  |
|---|--|
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Allergies to Aspirin    |
| <input type="checkbox"/> Chest pain / Angina                | <input type="checkbox"/> Allergies to Heat       |
| <input type="checkbox"/> High Blood Pressure                | <input type="checkbox"/> Allergies to Cold       |
| <input type="checkbox"/> Heart Disease                      | <input type="checkbox"/> Other Allergies         |
| <input type="checkbox"/> Heart Attack                       | <input type="checkbox"/> Hernia                  |
| <input type="checkbox"/> Heart Palpitations                 | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Pacemaker                          | <input type="checkbox"/> Metal Implants          |
| <input type="checkbox"/> Headaches                          | <input type="checkbox"/> Dizziness / Fainting    |
| <input type="checkbox"/> Kidney Problems                    | <input type="checkbox"/> Recent Fractures        |
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Surgeries               |
| <input type="checkbox"/> Bowel / Bladder Abnormalities      | <input type="checkbox"/> Skin Abnormalities      |
| <input type="checkbox"/> Liver / Gall Bladder Abnormalities | <input type="checkbox"/> Ringing in your Ears    |
| <input type="checkbox"/> Asthma / Breathing Difficulties    | <input type="checkbox"/> Nausea / Vomiting       |
| <input type="checkbox"/> Smoking                            | <input type="checkbox"/> Special Diet Guidelines |
| <input type="checkbox"/> Osteopenia / Osteoporosis          | <input type="checkbox"/> Rheumatoid Arthritis    |

Is there any information in your past medical history that we should know about?

Are you presently taking any medication? \_\_\_\_\_ if yes, please list medications:

Patient Name (Printed): \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## **HIPAA PRIVACY POLICY NOTICE**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Disclose health information in order to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.

Disclose your health information in order to receive payment for the services we provide to you.

Disclose your health information for normal healthcare operations such as quality assessments and physician certifications.

### **PATIENT RIGHTS REGARDING MEDICAL INFORMATION**

**The Right to Inspect and Copy Your Information:** You may review and copy your medical records and information.

**The Right to Amend:** You may ask that we amend your health information if you believe that your information is incomplete or incorrect.

**The Right to Request Restrictions:** You may request a restriction or limitation on how and what health information we disclose regarding you for treatment, payment of health operations or to your family or care-givers.

**The Right to Confidential Communications:** You may request that we communicate with you about medical matters in a certain format or a specific location.

**The Right to Receive a Copy of this Notice:** You may request and receive a copy of this notice (or our current notice) at any time by contacting this organization.

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Print Patient Name

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Relationship to Patient

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Signature

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Date

PATIENT NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ DATE: \_\_\_\_\_

**Description:** This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability.

**Please circle the answers below that best apply**

Please rate your pain level with activity: NO PAIN = 0    1    2    3    4    5    6    7    8    9    10 = VERY SEVERE PAIN

Pelvic Floor Distress Inventory Questionnaire - Short Form 20

			If <b>yes</b> , how much does it bother you?			
			Not at all	Somewhat	Moderately	Quite a bit
1.	Do you usually experience pressure in the lower abdomen?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>
2.	Do you usually experience heaviness or dullness in the lower abdomen?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>
3.	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>
4.	Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>
5.	Do you usually experience a feeling of incomplete bladder emptying?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>
6.	Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>
7.	Do you feel you need to strain too hard to have a bowel movement?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>
8.	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>
9.	Do you usually lose stool beyond your control if your stool is well formed?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>
10.	Do you usually lose stool beyond your control if you stool is loose or liquid?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>
11.	Do you usually lose gas from the rectum beyond your control?	<input type="checkbox"/> No <sup>(0)</sup>	<input type="checkbox"/> <sup>(1)</sup>	<input type="checkbox"/> <sup>(2)</sup>	<input type="checkbox"/> <sup>(3)</sup>	<input type="checkbox"/> <sup>(4)</sup>

12.	Do you usually have pain when you pass your stool?	<input type="checkbox"/> No (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
13.	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	<input type="checkbox"/> No (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
14.	Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	<input type="checkbox"/> No (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
15.	Do you usually experience frequent urination?	<input type="checkbox"/> No (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
16.	Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	<input type="checkbox"/> No (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
17.	Do you usually experience urine leakage related to laughing, coughing, or sneezing?	<input type="checkbox"/> No (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
18.	Do you usually experience small amounts of urine leakage (that is, drops)?	<input type="checkbox"/> No (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
19.	Do you usually experience difficulty emptying your bladder?	<input type="checkbox"/> No (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
20.	Do you usually experience pain or discomfort in the lower abdomen or genital region?	<input type="checkbox"/> No (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)

Therapist Only		
ICD9 Code: _____		
Comorbidities:		
<input type="checkbox"/> Cancer	<input type="checkbox"/> Obesity	<input type="checkbox"/> Multiple Treatment Areas
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Surgery for this Problem
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> High Blood Pressure	

## INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION

During the physical therapy evaluation for the problems you have reported, an assessment of your low back, hips, and pelvic girdle will be performed by a physical therapist in order to identify any musculoskeletal problems. This may include an evaluation of your pelvic floor muscles for strength, resting tone (tightness), and coordination (contract/relax). The findings will be discussed with you, and you will work with your physical therapist to develop a treatment plan that is appropriate for YOU. Your evaluation MAY include an internal assessment of the pelvic floor muscles, which could be completed vaginally (females) or rectally (males & females). A biofeedback assessment of your pelvic floor muscles may also be performed and may include internal or external sensors. Your physical therapist will discuss this option and receive your consent BEFORE initiating this exam. You absolutely can say NO, and your physical therapist can assess and treat the pelvic floor muscles externally (from the outside) if needed. The assessment of the pelvic floor muscles may result in soreness or discomfort temporarily. If this occurs, please discuss your symptoms with your physical therapist.

We realize that many patients may be apprehensive because of the private nature of the condition and the examination. Please ask as many questions as you need to increase your comfort and understanding of your evaluation, its findings, and treatment. Please discuss any concerns or hesitation that you may have with your physical therapist.

By signing this form, you agree and understand that treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat as discussed. You are always free to change your mind at any time during your course of treatment, and you are encouraged to notify your physical therapist of any changes of your preferences.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment (as described above). The second person could be a friend, family member, or clinic staff member. Please indicate your preference with your initials:

\_\_\_\_\_ **YES** I want a second person present during the pelvic floor muscle evaluation and treatment.

\_\_\_\_\_ **NO** I do not want a second person during the pelvic floor muscle evaluation and treatment.

\_\_\_\_\_ I would like to discuss my options with my physical therapist prior to consenting.

### CONSENT

I have read and understand the Informed Consent for Pelvic Floor Muscle Evaluation, and I consent to the evaluation and treatment, unless otherwise noted below.

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(Please list any exception to consent – if none, write none.)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_