Rehab Partners, Inc.
Health History Questionnaire Date_____

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name: _____ DOB: _____ Age: _____

What medical concerns bring you to our office? _____

How did you hear about our office? ☐ Doctor ☐ Friend/Family ☐ Advertisement ☐ Web ☐ Insurance

If disabled, check here: ☐ Nature of disability: _____

Do you exercise routinely? *(circle)* Yes No If yes, what exercise/how often? _____

Have you used tobacco products one or more times within the last 24 months? (circle) Yes No
If yes, was cessation counseling intervention received? (circle) Yes No

Have you completed Advanced Directives or do you have a Living Will? *(circle)* Yes No Which? _____

Tell us about your home environment: *(e.g. live alone or with family; house or apt; stairs? pets?)*

_____

Have you had 2 or more falls in the past year, or any one fall with injury in the past year? (circle) Yes No

Medical Information:

Allergies: _____

Have you ever been diagnosed with or treated for the following conditions? Check all that apply:

☐ Pacemaker	☐ Heart Attack	☐ High Blood Pressure	☐ Diabetes	☐ Stroke/TIA
☐ High Cholesterol	☐ Osteoporosis	☐ Rheumatoid Disease	☐ Osteoarthritis	☐ Seizures
☐ Asthma	☐ COPD	☐ TB/Lung Disease	☐ Pneumonia	☐ Anemia
☐ Thyroid Disease	☐ Lupus	☐ Multiple Sclerosis	☐ Fibromyalgia	☐ HIV/AIDS
☐ Liver Disease	☐ Kidney Disease	☐ Hepatitis A, B or C	☐ Digestive Disorder	
☐ Depression	☐ Anxiety	☐ Glaucoma	☐ Cataracts	

☐ Cancer (please specify type and year diagnosed):_____

PRESCRIPTION MEDICATION:	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:
OVER-THE COUNTER MEDICATION:	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:
HERBAL MEDICATION	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:
VITAMINS/MINERALS/DIETARY SUPPLEMENTS:	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:

Please list all illnesses, medical conditions and surgeries not discussed above:

_____

_____

_____

Personal Safety: (circle your answer)

Are you under a lot of pressure at work or home? Yes No If yes, which? _____

Do you have any safety concerns? Yes No

Do you have any difficulty obtaining or preparing 2 meals per day? Yes No

****

I certify that I have read and understand the above. I will not hold Rehab Partners, Inc. or any of its staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient's/Guardian's signature (or individual completing form for patient) Date

NIH-Chronic Prostatitis Symptom Index (Male)

Pain or Discomfort

In the last week, have you experienced any pain or discomfort in the following areas?
Area between rectum and testicles (perineum)

0: No

1: Yes

Testicles

0: No

1: Yes

Tip of penis (not related to urination)

0: No

1: Yes

Below your waist in your pubic area

0: No

1: Yes

In the last week, have you experienced:
Pain or burning during urination?

0: No

1: Yes

Pain or discomfort during or after sexual climax (ejaculation)?

0: No

1: Yes

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

Which number best describes your average pain or discomfort on the days that you had it, over the last week? (0= no pain and 10 = pain as bad as you can imagine)

0

1

2

3

4

5

6

7

8

9

10

Urination

How often have you had the 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 or always

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 or always

Impact of Symptoms

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

0: None

1: Only a little

2: Some

3: A lot

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

0: None

1: Only a little

2: Some

3: A lot

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

Urogenital Distress Inventory

Instructions

Do you experience, and if so, how much are you bothered by:

Frequent Urination?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

Night time Urination?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

Urine leakage related to the feeling of urgency?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

Urine leakage related to physical activity, coughing or sneezing?

- No
- Yes

If yes, how much does it bother you?

- Not At All
- Slighty
- Moderately
- Greatly

General urine leak not related to urgency or activity?

- No
- Yes

If yes, how much does it bother you?

- Not At All

Slighty

Moderately

Greatly

Small amounts of urine leakage (drops)?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

Large amounts of urine leakage?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

Difficulty emptying your bladder?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

Pain or discomfort in the lower abdominal or genital area?

No

Yes

If yes, how much does it bother you?

Not At All

Slighty

Moderately

Greatly

No= 0, Not at all= 1, Somewhat= 2, Moderately= 3, Quite a bit= 4
Obtain the mean value of all the answered items then multiply by 25 for the scale score. Missing items are dealt with by using the mean from the answered items only

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Continence Grading Scale: A Symptom Index

Incontinence For Solids Stool

0: Never (No episodes in the past 4 weeks)

1: Rarely (1 episode in the past 4 weeks)

2: Sometimes (More than 1 episode in the past 4 weeks but less than once per week)

3: Weekly (1 or more episodes per week but less than daily)

4: Daily (1 or more episodes per day)

Incontinence For Liquids Stool

0: Never (No episodes in the past 4 weeks)

1: Rarely (1 episode in the past 4 weeks)

2: Sometimes (More than 1 episode in the past 4 weeks but less than once per week)

3: Weekly (1 or more episodes per week but less than daily)

4: Daily (1 or more episodes per day)

Incontinence For Gas

0: Never (No episodes in the past 4 weeks)

1: Rarely (1 episode in the past 4 weeks)

2: Sometimes (More than 1 episode in the past 4 weeks but less than once per week)

3: Weekly (1 or more episodes per week but less than daily)

4: Daily (1 or more episodes per day)

Alteration In Lifestyle

0: Never (No episodes in the past 4 weeks)

1: Rarely (1 episode in the past 4 weeks)

2: Sometimes (More than 1 episode in the past 4 weeks but less than once per week)

3: Weekly (1 or more episodes per week but less than daily)

4: Daily (1 or more episodes per day)

Need To Wear Pad Or Plug

0: No

2: Yes

Taking Constipation Medicines

0: No

2: Yes

Lacking The Ability To Defer Defection For 15 Minutes

0: No

4: Yes

Minimum score 0: Perfect Continence
Maximum score: 24: Totally Incontinent

BLADDER RECORD

NAME: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

Revised 10.24.19

BLADDER RECORD

NAME: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

Revised 10.24.19

BLADDER RECORD

NAME: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
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11:00 AM				
12:00 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

DATE: _____

	Urinate in Toilet	Amount of Leak/Accident	Activity During Leak	Drink Type/Amount
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4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
TOTAL				

NUMBER OF PADS USED: _____

Revised 10.24.19

PELVIC FLOOR CONSENT FOR EVALATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor symptoms include, but are not limited to, urinary for fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin conditions, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but are not limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises soft tissue and/or joint mobilization, and educational instruction.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate this procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I have the option of having a second person present in the room during the procedure and ____ choose or ____ refuse this option. (please check one)

Date: _____ Patient Name: _____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature

REHAB PARTNERS, INC.

AUTHORIZATION FOR:
AUTHORIZATION FOR TREATMENT - ASSIGNMENT OF MEDICAL BENEFITS AND PAYMENT RESPONSIBILITY PT OT LMT

Patient's Name: _____
FACILITY / PROVIDER : REHAB PARTNERS, INC.

1.) **THE UNDERSIGNED**, hereby authorizes therapy at **REHAB PARTNERS, INC**. to render to patient Physical Therapy, Occupational Therapy, Massage Therapy or other related services (collectively, "Therapy Services") that provider or patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with the Provider's rendition of therapy services.
2.) **THE UNDERSIGNED**, hereby certifies that all information provided to the Provider by the undersigned or patient including any information in connection for applying for payment under title XVIII of the Social Security Act is true, correct and accurate in all respects.
3.) **THE UNDERSIGNED**, hereby authorize Provider to disclose any information furnished to the Provider or obtained by Provider in connection with the patient's treatment (including information concerning a related Medicare claim) to any physician, governmental agency (including the Social Security Administrations or any of its intermediaries or carriers) insurance company or health care facility requesting such information.
4.) **THE UNDERSIGNED**, hereby assign to Provider all Medicare benefits to which the patient may be entitled for any therapy services rendered by the Provider. The undersigned hereby authorize and direct the Provider to apply and file for all such benefits on behalf of the patient in the event the patient is covered by both Medicare and Medicaid. The undersigned acknowledge that the Provider has disclosed to the undersigned that the Provider is a supplemental Medicaid Provider and the Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical or claims management purposes.
5.) **THE UNDERSIGNED**, hereby assign to the Provider all Private Medical Insurance benefits (primary and secondary, including med gap providers) or other benefits to which the patient may be entitled for any therapy services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of the patient.
6.) **THE UNDERSIGNED**, agree that the undersigned shall be jointly and severally financially responsible for any portion of the Providers invoice that is not paid, except in the case of a Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to the Provider if member is a Medicare participant that patient is not a member of or covered by a Health Maintenance Organization or similar arrangement as their primary insurance coverage. The undersigned shall be liable to Provider for all services rendered by Provider in the event the patient is covered by a Health Maintenance Organization or similar arrangement.
7.) **THE UNDERSIGNED**, and patient if applicable agree to execute any documents and perform any acts that the Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any Powers of Attorney, Health Care Surrogate or Court Orders appointing the undersigned as the legal guardian of the patient.
8.) **THE UNDERSIGNED**, agree that the provisions hereof shall continue in full force and effect until Provider received written notice of termination by the undersigned: provided however that the provisions in paragraphs 1,2,3,4,5,6, and 7 shall survive any such termination.

WITNESSES:

_____

_____

_____

X _____
PATIENT SIGNATURE / LEGAL REPRESENTATIVE

DATE:_____

_____
FINANCIALLY RESPONSIBLE PARTY IF NOT PATIENT

DATE: _____

HIPAA NOTIFICATION

REHAB PARTNERS, INC. IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION AND TO PROVIDE YOU NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES AND ADHERE TO THIS NOTICE. WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE DO CHANGE OUT INFORMATION PRACTICES, WE WILL POST A NOTICE THAT THE NOTICE HAS CHANGED AND THE EFFECTIVE DATEOF THE CHANGE. COPIES WILL BE MADE AVAILABLE UPON REQUEST.

I UNDERSTAND THAT REHAB PARTNERS, INC. HAD MADE AVAILABLE TO ME A COPY OF THE NOTICE OF PRIVACTY PRACTICES. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES.

PATIENT SIGNATURE: _____

DATE: _____

Because of the nature of this practice, it may be necessary to contact you by telephone for examination results, scheduling, appointments, billing, etc. HIPAA requires that we obtain specific consent from our patients allowing us to speak with others on your behalf should you not be available. Please indicate below the names, relationships, and date of birth of those you will allow us to speak with on your behalf. This would include your SPOUSE, FAMILY MEMBERS, CARE GIVERS, ETC.

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

If you **DO NOT** want us to speak with anyone with regards to your treatment, appointments, billing, etc. please indicate so by signing below.

NAME: _____

DATE: _____