Limitless Physical Therapy

Patient Intake Information

Welcome to Limitless Physical Therapy. Our Physical Therapists and staff take pride in providing you individualized care and impeccable customer service. To best serve you, we need to gather some information about you. If you have any questions, please ask.

Name: _____ Date: _____

Height: _____ Weight: _____

WHAT BRINGS YOU IN?

Injury/Condition: _____ When did your symptoms begin? ___ months ago or ___ years ago

What caused your injury/condition? _____

How has your lifestyle or quality of life been affected by this problem (social activities, physical activity, diet changes, work)? _____

Have you seen another provider for this problem **Y** **N** If yes, when? _____

Have you had imaging done for this problem? **Y** **N** If yes, what kind? _____

Have you had any previous treatment for this problem? **Y** **N** If yes, please describe: _____

_____

TELL US ABOUT ANY PAIN YOU EXPERIENCE

My pain is like **(Circle all that apply)**:

numbness sharp dull achy

burning tingling throbbing no pain

I feel this pain **(Circle all that apply)**:

constantly intermittently inconsistently

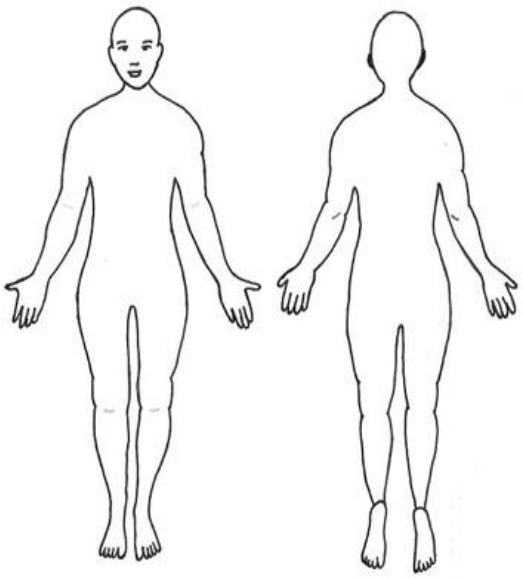
Rate your pain level **0 - 10 (0 = No Pain; 10 = Severe Pain)**:

Currently: _____ At its best: _____ At its worst: _____

What activities make your pain worse? Check any that apply

__ Sitting more than __ minutes
__ Walking more than __ minutes
__ Standing greater than __ minutes
__ Changing positions (eg – sit to stand)
__ Cough/sneeze/laugh
__ Lifting/bending
__ Sexual activity
__ Other: _____

Mark where you have pain



OB/GYN HISTORY

1. Do you have any of the following symptoms? (Check any that apply):

__ Painful periods __ Pelvic pain __ Pelvic heaviness or sensation of "falling out"
__ Irregular periods __ Heavy periods __ Frequent UTIs

__ Painful/impossible vaginal penetration (eg. tampons) __ History of STI

__ Period-related constipation or diarrhea

2. Total # of pregnancies: ____

3. Total # of vaginal deliveries: ___ Year/s delivered: _____

Tearing or episiotomy (circle) **Y N** If yes, what grade? **1 2 3 4 not sure**

4. Total # of c-section deliveries: ___ Year/s delivered: _____

5. Any complications from pregnancy or childbirth? Describe: _____

_____

6. Please describe current sexual practices (Check all that apply):

__ Active with men __ Active with women __ Not sexually active / abstinent

__ Other: _____

7. Current birth control method (Check all that apply):

__ Abstinence __ Condoms/barriers __ Hormonal birth control, type: _____

__ Non-hormonal birth control, type: _____

8. Do you have a history of sexual assault or trauma? **Y N**

If yes, are you okay with discussing? **Y N**

BLADDER HISTORY

1. Frequency of urination:

__ times per day, __ times at night (waking up from sleep)

2. The normal amount of urine passed is:

__ small __ medium __ large

3. Check any of the following symptoms you experience:

__ Difficulty initiating urine stream __ Intermittent/slow stream

__ Difficulty emptying bladder fully __ Straining or pushing to empty

__ Dribbling after urination __ Difficulty stopping urine stream

__ Difficulty feeling the urge to go __ Blood in urine __ Painful urination

4. Describe fluid intake:

Number of 8 oz cups of water: ___ Total caffeinated beverages: ___

5. Are you experiencing urinary leakage/incontinence? **Y N**

a. If yes, how often? __ times per day __ times per week __ times per month

__ Only with specific activity, describe_____

b. What causes leakage? __ Cough, laugh, or sneeze __ Yelling __ Running __ Jumping

__ Squatting, lifting, rising from a chair __ With urge __ Unpredictable, or not sure what causes

b. How much urine do you leak? Check one: __ Few drops __ Wets underwear

__ Wets outerwear __ Complete emptying

c. What form of protection do you wear? __ None __ Light liner __ Medium/heavy liner

__ Specialty product/diaper How many pads/day? ___ #

6. When you have a normal urge to urinate, how long can you delay before you have to void? (Check one):

__ indefinitely __ >2 hours __30-60 minutes __10-20 minutes __ less than 5 minutes __ not at all

7. If urgency/frequency is a concern, what makes your urgency worse? (Check all the apply):

__ Triggers (running water, key in the door) __ With nervousness/anxiety

__ Physical activity __ Cold weather __ Specific foods/drink, describe:_____

BOWEL HISTORY

1. Frequency of bowel movements (BMs): __ times per week

2. The normal consistency is (Check all that apply):

__ Small, hard lumps __ Lumpy and hard to pass __ Smooth, easy to pass

__ Soft blobs with clear edges __ Mushy without clear edges __ Liquid

3. Check any of the following symptoms you experience:

__ Difficulty initiating a BM __ Pressure in vaginal area with BMs __ Difficulty emptying fully

__ Blood in stool __ Excessive wiping to feel clean after BM __ Pain with BM

4. How long can you delay the urge to have a BM? __ Minutes __ Hours __ Indefinitely

5. Are you experiencing bowel incontinence? **Y** **N**

If yes, when? __ With bowel urge __ With physical activity __ Leakage within an hour after having a BM __ Other (describe): _____

GOALS

List 3 activities you are limited in currently? **Rate the difficulty 0 - 10 (0 = Cannot do at all; 10 = No difficulty)**

1. _____
2. _____
3. _____

HEALTH HISTORY

Please list all medications you are currently taking (If more than 3 ask us for a med sheet): _____

_____

Is this injury the result of a fall? **Y N**

Have you fallen in the past year? **Y N** If yes, how many times? _____

Have you recently had any of the following? **(Circle all that apply):**

Bladder Difficulties	Bowel Difficulties	Breathing Difficulty	Insomnia	Weakness
Change in Vision	Nausea/Vomiting	Weight Loss	Fatigue	Fever/Chills/Sweats
Pain at night	Pregnancy			

Do you currently have or have had any of the following? **(Circle all that apply):**

Allergies/Skin Sensitivity	Anxiety	Asthma/Breathing Problems	Autoimmune Deficiency
Cancer	Circulation Problems	Depression	Diabetes
Easy bruising/bleeding	Fainting	Fractures	Heart Problems
Hepatitis	High Blood Pressure	Indigestion/Heartburn	Kidney Disease
Leg/Ankle Swelling	Loss of consciousness	Lung Disease	Metal Implant
Motor Vehicle Accident	Multiple Sclerosis	Osteoporosis/Osteopenia	Pacemaker
Smoking	Sprains/Strains	Stroke	Surgeries
Thyroid Problems	Urinary Problems/Infections		

At the current time would you rate your overall health as **(Circle one)**:

Excellent	Very Good	Good	Fair	Poor

PERSONAL INFORMATION

Name: Last _____ First _____ Middle _____

Preferred _____ DOB: _____ Gender: M F

Address: _____

Ph #: _____ Cell/Home/Work (circle): **OK TO LEAVE MESSAGES? (Circle one): YES NO**

Alt. Ph #: _____Cell/Home/Work (circle): **OK TO LEAVE MESSAGES? (Circle one): YES NO**

Email: _____

I prefer appointment reminders via **(Circle one)**: Text Email Phone Call

If text, my cell carrier is: _____ (Please note that standard text messaging rates may apply)

Emergency Contact: _____ Ph #: _____ Relationship: _____

Physician's Name: _____ Clinic: _____

Other Current Healthcare Provider: _____ Clinic: _____

How did you hear about us?

☐ Referring Provider ☐ Friend/Family ☐ Radio

☐ Facebook ☐ Online ☐ Other _____

INSURANCE INFORMATION

Are you the primary subscriber on the plan?: **YES** **NO**

If you are **NOT** the primary subscriber, please complete:

Subscriber (primary on plan) exactly as it appears on card: _____

Member ID#: _____ Group #: _____ Policy #: _____

Subscriber's DOB: _____ Subscriber Gender: M F Subscriber Ph #:_____

Subscriber's Address: _____

Responsible Party: _____

Claim # (If Worker's Compensation or Auto Accident): _____

State where accident/injury occurred: _____

If responsible party is someone other than yourself or the subscriber, please provide the following:

Name: _____ Relationship to patient: _____ Responsible Party's DOB: _____

Ph #: _____ Address: _____

Please read the information below carefully and let us know if you have any questions or concerns.

You are voluntarily consenting to evaluation and treatment by Limitless Physical Therapy. You have the right to decline any procedures after discussing the risks and benefits with your physical therapist.

We request 24 hours notice when cancelling appointments. If you fail to provide 24 hours notice and we cannot reschedule your appointment during the following business day, you will be charged a $40.00 fee.

We will verify your insurance benefits as a courtesy to you and will communicate that information to you, but you understand that this information is not a guarantee of payment. You authorize Limitless Physical Therapy to communicate with your insurance company in order to collect payment for the services provided to you, unless you have chosen to pay for services out of pocket. You are responsible for payment at the time of service. Depending on your insurance benefits, or if you are paying out of pocket for services, you are responsible for the applicable co-pays, co-insurance, payment toward your deductible or payment for the cost of each visit. You must make a payment each visit unless prior arrangements have been made with Limitless Physical Therapy.

Phone calls to the main clinic line (541) 704-7770, and faxes to the clinic fax number (541) 704-7773 are the only secure means to contact Limitless Physical Therapy. If you choose to contact the clinic or physical therapist via other means, including but not limited to Facebook message, email, or personal phone number, your personal information cannot be secured.

We have provided you a copy of our HIPAA-Privacy Policy, additional copies can be made available to you upon request.

*By signing, you agree to all the above. If you have questions or concerns, please return to the front desk and discuss with one of our Customer Service Specialists prior to signing.

Signature: _____ Date: _____