This information is strictly confidential. Your answers will provide the therapist with important information to consider if physical therapy can help you. Please be as accurate as possible.

I hereby authorize Dr. Kim Bryant, PT, DPT to examine and treat my condition as she deems appropriate through the use of physical therapy and I give authority for these procedures to be performed.

Signature of Patient, Spouse or Guardian_____Date_____

Please do not wear strong perfumes, aftershaves or other scents to the office; some patients are allergic.
Thank you!

PLEASE FILL OUT and BRING WITH YOU to your first appointment or electronically submit to kimb@kimbryantpt.com ***prior to 1st visit.***

Patient Information

Name_____Gender M F T (circle)____DOB_____Age_____Date_____

Address: _____

Phone:_____(home)_____(cell)_____(work)

Occupation (or previous if retired) _____

E-mail: _____ Marital Status: (circle) Single Married Widowed Divorced
Height:_____Current Weight_____lbs

Medical Doctor:_____Phone:_____Fax: _____
Address: _____

Referred to this office by:_____Phone: _____
Fax: _____
Address: _____

Emergency Contact:_____Phone: _____

Have a prescription for physical therapy from a doctor?_____(A doctor prescription is not required, though insurance companies may require one for reimbursement)

Please check:
_____ Yes, please include me on your seasonal e-letter mailing that provides updates about pelvic health and clinic happenings.

_____ No thank you, please do not add my e-mail to your seasonal e-letter mailing.

Patient History

1. Describe the current problem that brought you here?_____
_____

2. When did your problem first begin?_____

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____
_____

4. Since that time is it: staying the_____same_____getting worse_____getting better
Why or how?_____

5. If pain is present rate pain on a 0-10 scale 10 being the worst._____

6. Describe the nature of the pain (i.e. constant burning, intermittent ache)_____
_____

7. Describe previous treatment/exercises_____
_____

8. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___Sitting greater than_____minutes
___Walking greater than_____minutes
___Standing greater than_____minutes
___Changing positions (ie. - sit to stand)
___Light activity (light housework)
___Vigorous activity/exercise (run/weight lift/jump)
___Sexual activity
___Other, please list _____

___With cough/sneeze/straining
___With laughing/yelling
___With lifting/bending
___With cold weather
___With triggers i.e. /key in door
___With nervousness/anxiety
___No activity affects the problem

9. What relieves your symptoms?_____
_____

10. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

11. What are your treatment goals/concerns?_____
_____
_____

Since the onset of your current symptoms have you had:

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder functions
Y/N Other /describe_____

Y/N Malaise (unexplained tiredness
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness /Tingling Location: _____

Date of Last Physical Exam_____Tests performed_____

General Health: Excellent Good Average Fair Poor

Occupation _____ Hours/week_____On disability or leave Activity Restrictions? _____

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

Describe _____

Mental Health: Current level of stress High Med Low Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression and/or anxiety	Acid Reflux /Belching	Hepatitis
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe_____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries #	Y/N	Vaginal dryness
Y/N	Episiotomy #___	Y/N	Painful periods
Y/N	C-Section #____	Y/N	Menopause - when? _____
Y/N	Difficult childbirth #___	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic/genital pain_____

Y/N Other /describe_____

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation

Y/N Pelvic/genital pain location _____

Y/N Other /describe_____

Medications - pills, injection, patch Start date Reason for taking

_____

_____

_____

_____

Over the counter -vitamins etc Start date Reason for taking

_____

_____

_____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Symptoms

Y/N	Trouble initiating urine stream	Y/N	Blood in stool/feces
Y/N	Urinary intermittent /slow stream	Y/N	Painful bowel movements (BM)
Y/N	Strain or push to empty bladder	Y/N	Trouble feeling bowel urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Seepage/loss of BM without awareness
Y/N	Trouble emptying bladder completely	Y/N	Trouble controlling bowel urge
Y/N	Blood in urine	Y/N	Trouble holding back gas/feces
Y/N	Dribbling after urination	Y/N	Trouble emptying bowel completely
Y/N	Constant urine leakage	Y/N	Need to support/touch to complete BM
Y/N	Trouble feeling bladder urge/fullness	Y/N	Staining of underwear after BM
Y/N	Recurrent bladder infections	Y/N	Constipation/straining_____% of time
Y/N	Painful urination	Y/N	Current laxative use -type _____
Y/N	Other/describe _____		

Describe typical position for emptying: _____

1. Frequency of urination: awake hours _____times per day, sleep hours_____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   _____minutes,_____ hours,_____not at all
3. The usual amount of urine passed is: ____small____medium_____large
4. Frequency of bowel movements____times per day,_____times per week, or_____.
5. The bowel movements typically are: watery____loose____formed____pellets____other _____
6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
_____minutes,_____hours,_____not at all.
7. If constipation is present describe management techniques _____
8. Average fluid intake (one glass is 8 oz or one cup)_____glasses per day.
   Of this total how many glasses are caffeinated?____glasses per day.

9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your menstrual period)
___With standing for_____minutes or_____hours.
___With exertion or straining
___Other_____

10a. Bladder leakage - number of episodes
___No leakage
___Times per day
___Times per week
___Times per month
___Only with physical exertion/cough

10b. Bowel leakage - number of episodes
___No leakage
___Times per day
___Times per week
___Times per month
___Only with exertion/strong urge

11a. On average, how much urine do you leak?
___No leakage
___Just a few drops
___Wets underwear
___Wets outerwear
___Wets the floor

11b. How much stool do you lose?
___No leakage
___Stool staining
___Small amount in underwear
___Complete emptying
___Other _____

12. What form of protection do you wear? (Please complete only one)
___None
___Minimal protection (tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxi pad)
___Maximum protection (specialty product/diaper)
___Other _____

On average, how many pad/protection changes are required in 24 hours?_____# of pads

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

_____I understand that I am a patient of Kim Bryant, PT, DPT who is an independent Physical Therapy practitioner practicing under Kim Bryant Physical Therapy, LLC, at 15833 S 38th St Phoenix, AZ 85048. This office is not a group practice, but rather an independent practitioner's office.

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

_____**Cancellation Policy**: I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance or fail to come to a scheduled appointment, I will pay a cancellation fee of $50.00.

_____**No warranty**: I understand that Kim Bryant Physical Therapy, LLC and Kim Bryant, PT, DPT cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that Kim Bryant, PT, DPT will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

_____**Potential risks:** I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

_____**Potential benefits** may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

_____**Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:

I authorize the release of my medical records to my physicians/primary care provider or insurance company. Please list.

_____

Financial and insurance responsibilities if private pay:

_____I agree to pay for my evaluation and treatments at the time of service, by cash, check, or charge card. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will provide me with a receipt that is my responsibility to submit to my insurance company.

I have read the above information and I consent to physical therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

_____ _____

Print Name Date

_____ _____

Patient's signature (if minor, parent or legal guardian must sign) Therapist Signature / Date

NOTICE OF PRIVACY PRACTICES

PLEDGE REGARDING MEDICAL INFORMATION

I understand that medical information about you and your health is personal. I am committed to protecting medical information about you. I create a record of the care and services you receive at the practice. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your physicians or others working in this office.

Rights Regarding Health Information

- Right to Inspect and Copy.
- Right to Amend.
- Right to an Accounting of Disclosures.
- Right to Request Restrictions.
- Right to Request Confidential Communications.

You will be asked to acknowledge and sign a notice regarding HIPAA (the acronym for the Health Insurance Portability and Accountability Act) on your initial visit with Kim Bryant, PT, DPT.