restore
physical therapy

966 NW Circle Boulevard, Corvallis, OR 97330 p: 541-908-7959 f: 541-207-3062 ptrestore@gmail.com

Patient Information

Full Name: ______________________________ Date of Birth: ______________

Address: ____
Street Address Apartment/Unit #

____
City State Zip Code

Primary Phone: ______________________ Alternate Phone: ______________________

Email: ______________________ Occupation: ______________________

How did you hear about Restore PT?: ______________________________

Emergency Contact Information

Full Name: ______________________ Relationship: ______________________

Primary Phone: ______________________ Alternate Phone: ______________________

Medical History

Do you now have or have you ever had any of the following conditions?

	Now	Past		Now	Past
Asthmas, Bronchitis, or Emphysema	_____	_____	Cancer	_____	_____
Shortness of Breath/ Chest Pain	_____	_____	Arthritis	_____	_____
Heart Disease or Angina	_____	_____	Stroke/TIA	_____	_____
Heart Attack or Surgery	_____	_____	Diabetes	_____	_____
High Blood Pressure	_____	_____	Gout	_____	_____
Do You Have a Pacemaker?	_____	_____	Anemia	_____	_____
Blood Clot or Emboli	_____	_____	Allergies	_____	_____
Infectious Diseases	_____	_____	Osteoporosis	_____	_____
Vision or Hearing Problems	_____	_____	Hernia	_____	_____
Thyroid or Goiter Problems	_____	_____	Anxiety/Depression	_____	_____
Dizziness or Fainting	_____	_____	Weight Loss	_____	_____
Metal in Body or Surgical Implants	_____	_____	Weight Gain	_____	_____
Bowel or Bladder Problems	_____	_____	Joint Replacement	_____	_____

Are you currently pregnant? (circle one): NO YES Estimated date of delivery: ______________

List all surgical procedures you have had:

____

____

Other Conditions:

____

____

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CONDITIONS OF TREATMENT AND CONSENT FOR PHYSICAL THERAPY

PATIENT'S INITIALS	At Restore Physical Therapy we strive to provide you with the best, personalized care. To make this possible we ask you to adhere to the very important policies below. Please read them carefully, initial all of the boxes, and indicate your agreement with these policies by signing at the bottom.
	CONSENT FOR TREATMENT: I consent to and authorize my physical therapist to provide care and treatment prescribed by and considered necessary or advisable by the treating physical therapist and/or my physician(s). I acknowledge that no guarantees have been made to me about the results of treatment.
	ATTENDANCE/COMPLIANCE and COOPERATION WITH TREATMENT: I understand that in order for physical therapy treatment to be effective, I must attend my scheduled appointments and arrive on time, unless there are unusual circumstances that prevent me from attending therapy.I agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with my program, I will discuss it with my therapist.
	CANCELLATION/NO SHOW POLICY: Please call 541-908-7959 or email ptrestore@gmail.com if you need to cancel your appointment.. We have an ongoing waitlist and therefore require at least a 24 hour notice for cancellation or rescheduling.Cancellations have a serious impact on the clinic. **No shows or cancellations less than 24 hours in advance will be charged the full visit fee.**
	PHYSICAL THERAPY SCRIPT/REFERRAL: You may have an evaluation and treatment for PT without a script/referral. PLEASE NOTE: Your insurance may require a script/referral PRIOR to beginning PT. You can obtain a script from a physician, podiatrist, psychologist, chiropractor, dentist, physician assistant or nurse practitioner.. For more information, please see the "Insurance Benefit Worksheet" so you know how to inquire about your insurance out-of-network PT benefits (find the worksheet at restoreptcorvallis.com/forms).
	MEDICARE PATIENTS: Restore PT does not accept Medicare and patients cannot be reimbursed by Medicare for services received at Restore PT.
	FINANCIAL POLICY: For optimal patient care, Restore Physical Therapy has chosen to be an out-of-network provider. By not having a preferred provider/contracted status with insurance companies, your PT does not have to limit the time or quality of treatment provided secondary to insurance company restrictions, or elevate clinic rates to pay for billing services. Upon your request, we will give you a receipt of your services that you can submit to insurance for reimbursement if you have out-of-network insurance benefits or to apply toward your annual deductible. We accept cash, check, debit or credit card payment at the time of your service (*cash or check is preferred*). You may also use your Health Savings or Flex Spending Account to pay for your services. The rates are as follows: $162.50 for Initial Evaluation + Treatment (75 minutes) --- $130 for Follow-up Treatments (60 minutes).
	HIPAA AUTHORIZATION: We understand that health information about you is personal and we are committed to protecting it. We create a record of the care, services and assessments you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the health-related records of your care generated by Restore PT, whether made by your personal treating practitioner or others working within Restore PT. You acknowledge you have viewed the Notice of Privacy Practices (online or in person) written in plain language, which provides in detail the uses and disclosures of your protected health information, your individual rights, how you may exercise these rights, and Restore PT's legal duties with respect to your protected health information. Restore PT is required by law to: ● Make sure that health information that identifies you is kept private. ● Give you this notice of our legal duties and privacy practices with respect to health information about you. ● Not retaliate against you for filing a complaint.

I have read the above information, and I consent to physical therapy evaluation and treatment. I have asked any questions and they have been answered to my satisfaction. I understand the risks, benefits and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

____ ____________________

Signature of Patient or Guardian Date

____

Printed Name of Patient or Guardian

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CONSENT FORM INTERNAL PELVIC FLOOR EVALUATION

In order to fully understand the scope of your individual diagnosis, there is important information your physical therapist needs.

Please be brief in your answers. If your physical therapist needs you to expand upon your answers, she will ask you privately.

1. Are you currently sexually active? _____ YES _____ NO

   If "No", have you been in the past? _____ YES _____ NO

2. Do you have any communicable diseases? _____ YES _____ NO

   If "Yes", please explain: ____

3. Has there been any sexual abuse in your past? _____ YES _____ NO

4. Have you had difficulty in the past with vaginal exams? _____ YES _____ NO

I give / deny (circle one) my consent for the physical therapist to do a vaginal/rectal examination for the purpose of evaluating my condition and giving therapeutic treatment.

1. I understand I can terminate the procedure at any time.
2. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the procedure.
3. I have the option of bringing a second person to be in the room with me during the procedure, and I refuse / choose (circle one) this option.
4. I have read this consent form and understand its terms.

____ ______________________

Signature of Patient or Guardian Date

____

Printed Name of Patient or Guardian

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PELVIC QUESTIONNAIRE

PELVIC AND ABDOMINAL PAIN

WHERE IS YOUR PAIN: ☐ Vagina ☐ Vulva ☐ Pubic Bone ☐ Tailbone ☐ Sacrum ☐ SI Joint ☐ Lumbar ☐ Hip(s) ☐ Abdomen
DESCRIPTION: ☐ None ☐ Yes: ☐ Stabbing ☐ Aching ☐ Tender ☐ Sore ☐ Burning ☐ Prickling ☐ Sharp ☐ Shooting
HOW IS PAIN AFFECTED:
WHAT INCREASES YOUR PAIN:
WHAT DECREASES YOUR PAIN:
TIME OF DAY: ☐ Unaffected MORNING: ☐ Increase ☐ Decrease AFTERNOON: ☐ Increase ☐ Decrease EVENING: ☐ Increase ☐ Decrease NIGHTTIME: ☐ Increase ☐ Decrease
FULL BLADDER: ☐ Unaffected ☐ Increase ☐ Decrease
URINATION: ☐ Unaffected ☐ Increase ☐ Decrease
BOWEL URGE: ☐ Unaffected ☐ Increase ☐ Decrease
DURING BOWEL MOVEMENT: ☐ Unaffected ☐ Increase ☐ Decrease
AFTER A BOWEL MOVEMENT: ☐ Unaffected ☐ Increase ☐ Decrease
VAGINAL PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease
INITIAL PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease
DEEP PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease
ORGASM: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease
FOLLOWING PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase, Duration pain lasts:
ARE YOU ABLE TO ACHIEVE AN ORGASM? ☐ No ☐ Yes ☐ Unsure
MARINOFF SCALE – DESCRIPTIVE SCALE OF INTERCOURSE ☐ N/A
☐ 0: No problems ☐ 2: Pain interrupts or prevents completion ☐ 1: Discomfort that does not affect completion ☐ 3: Pain preventing any attempts at intercourse
CONTACT WITH CLOTHING: ☐ Unaffected ☐ Increase ☐ Decrease
ABDOMINAL PAIN OR BLOATING: ☐ N/A ☐ No ☐ Yes. Explain:
DIGESTIVE ISSUES? ☐ No ☐ Past ☐ Present. Explain: ☐ Food Allergy or Intolerance ☐ IBS ☐ IBD ☐ Leaky Gut ☐ SIBO ☐ Colon Dysbiosis ☐ Ulcerative Colitis ☐ Crohn's
PAIN FROM EATING: ☐ No ☐ Yes. Explain: | PAIN FROM DRINKING: ☐ No ☐ Yes. Explain:
RATE YOUR PAIN (0=NONE, 10=WORST PAIN IMAGINABLE)? Current: _____ /10 At best?: _____ /10 At worst?: _____ /10

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OBSTETRICS/GYNECOLOGICAL HISTORY

ARE YOU CURRENTLY PREGNANT? ☐ No ☐ Yes. DUE DATE: _____/_____/_____ NUMBER OF WEEKS GESTATION: ______

IF PREGNANT, ARE YOU HIGH RISK? ☐ No ☐ Yes

DO YOU HAVE MTHFR? ☐ No ☐ Yes. Explain:

CURRENT SUPPLEMENTS:

NUMBER OF PREGNANCIES: _______ NUMBER OF DELIVERIES: VAGINAL _____ C-SECTION _____ V-BACK _____

DATES OF DELIVERIES: ____/_____/_____ , ____/_____/_____ , ____/_____/_____ , ____/_____/_____ , ____/_____/_____

BIRTH WEIGHTS:

CURRENTLY BREASTFEEDING? ☐ No ☐ Yes

EPISIOTOMY OR PERINEAL TEAR? ☐ No ☐ Yes. Explain:

DIFFICULT CHILDBIRTH? ☐ No ☐ Yes. Explain:

POST PARTUM DEPRESSION OR BABY BLUES? ☐ No ☐ Yes ☐ Unsure. Explain:

DO YOU HAVE DIASTASIS RECTI? ☐ No ☐ Yes ☐ Unsure. Explain:

DIFFICULTY CONCEIVING? ☐ No ☐ Yes. Explain:

OF MISCARRIAGES _____
OF INFANT LOSSES _____
OF ABORTIONS ____

MENSTRUATION: ☐ N/A CYCLE LENGTH: __________ Days

DURATION OF PERIOD (BLEEDING): __________ Days

PAINFUL PERIODS? ☐ No ☐ Yes. Explain:

VAGINAL DRYNESS?
☐ No ☐ Yes. Explain:

CURRENTLY ON BIRTH CONTROL? ☐ No ☐ Yes. Name:

TOTAL MONTHS/YEARS ON BIRTH CONTROL: __________

DATE OF LAST PELVIC EXAM: _____/_____/_____

RESULTS:

MENOPAUSE? ☐ No ☐ Yes.
When: :

HISTORY OF PHYSICAL OR SEXUAL ABUSE? ☐ No ☐ Yes.

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Please tell me if there is anything related to previous abuse that might impact our examination and/or treatment.

HISTORY OF STD's CURRENT OR PAST? ☐ No ☐ Yes. Explain:

IF PAST, PLEASE LIST CURE DATE: _____/_____/_____

CURRENT YEAST INFECTION? ☐ No ☐ Yes	HISTORY OF YEAST INFECTIONS? ☐ No ☐ Yes. How many? _____

CURRENT URINARY TRACT INFECTION (UTI)? ☐ No ☐ Yes	HISTORY OF UTI's? ☐ No ☐ Yes. How many? _____

DO YOU USE LATEX CONDOMS? ☐ No ☐ Yes	DO YOU USE VAGINAL LUBRICANTS? ☐ No ☐ Yes. Brand(s)?

DO YOU USE BATH SALTS, VAGINAL SPRAYS, DOUCHES? ☐ No ☐ Yes. Explain:	DO YOU USE ANY OTHER VAGINAL CREAMS OR MEDICINE? ☐ No ☐ Yes. Explain:

BLADDER

WAS THERE AN EVENT ASSOCIATED WITH ONSET OF URINARY COMPLAINTS?: ☐ No ☐ Yes. Please describe:

URINE STREAM: ☐ Easy to Start ☐ Difficult to Start ☐ Strong ☐ Weak ☐ Starts & Stops ☐ Deflects to one side

EMPTYING: ☐ Complete ☐ Incomplete ☐ Pushing or straining needed ☐ Retention ☐ Other:	ANY DRIBBLING AFTER URINATION?: ☐ No ☐ Yes

FREQUENCY OF URINATION: During awake hours? _____ # times per day During Sleep Hours? _____ # times per night

DO YOU FEEL AN INTENSE URGE TO URINATE? ☐ No ☐ Yes ☐ Unsure

URINARY SENSATION PRESENT: ☐ No ☐ Yes ☐ Variable	ONCE YOU GET THE URGE, CAN YOU HOLD BACK FROM VOIDING?: ______ minutes, _____ hours	COLOR OF URINE:

WHAT IS THE AVERAGE VOLUME OF URINATION? Specify oz OR count seconds ☐ ______ oz ☐ ______ seconds	WHAT DO YOU DRINK ON A NORMAL DAY?

HOW MANY OUNCES OF WATER PER DAY?	HOW MUCH CAFFEINE? ☐ None ☐ Yes, Please describe:

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CAN YOU STOP YOUR URINE ONCE STARTED?: ☐ Complete ☐ Deflects ☐ Unable

DO YOU KEGEL WHEN YOU URINATE? ☐ No ☐ Yes ☐ Sometimes

PAIN OR BURNING WITH URINATION?: ☐ No ☐ Yes

PAIN WITH WIPING?: ☐ No ☐ Yes

HOW DO YOU WIPE? ☐ Front to back ☐ Back to front ☐ Other. Explain:

PROLAPSE OR FEELING OF FALLING OUT OR HEAVINESS IN PELVIS: ☐ No ☐ Yes
☐ With Menses ☐ Standing ☐ Straining ☐ At the end of the day ☐ All the time

DO YOU VOID "JUST IN CASE"?: ☐ No ☐ Yes

DO YOU HOVER OVER PUBLIC TOILETS TO VOID: ☐ No ☐ Yes

DID YOU EXPERIENCE ANY URINARY ISSUES AS A CHILD ☐ No ☐ Yes. Please describe:

URINARY LEAKAGE

URINARY LEAKAGE: ______ # episodes per ☐ Day ☐ Week ☐ Month

CAUSE: ☐ None ☐ Cough ☐ Sneeze ☐ Laugh ☐ Lift ☐ Sit<>Stand ☐ Walking ☐ Jumping ☐ Running

☐ On the way to the bathroom ☐ Sound of running water ☐ Key in the door ☐ Other: ______________________________

URINE LEAKAGE AMOUNT: ☐ None ☐ Few Drops ☐ Wets Pad ☐ Wets Underwear ☐ Wets Outerwear

DO YOU WEAR A PAD OR PROTECTIVE DEVICE?: ☐ No ☐ Yes. What kind?

PAD(S) CHANGES REQUIRED IN 24 HOURS:

HAVE YOU EVER TAKEN MEDICINE TO PREVENT URINE LOSS: ☐ No ☐ Yes. Explain:

BOWEL HABITS

WAS THERE AN EVENT ASSOCIATED WITH ONSET OF BOWEL COMPLAINTS?: ☐ None ☐ Yes. Please describe:

BOWEL SENSATION PRESENT?: ☐ No ☐ Yes ☐ Variable

CAN YOU HOLD BACK YOUR FECES IF NO BATHROOM IS AROUND?: minutes, hours

FREQUENCY OF BOWEL MOVEMENTS: # times per day, # times per week

EVACUATION HABITS: ☐ None ☐ Straining ☐ Splinting ☐ Other Explain:

COLOR OF YOUR POOP:

IS YOUR STOOL: ☐ LIQUID ☐ SOFT ☐ NORMAL ☐ FIRM ☐ HARD

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LAXATIVE USE: ☐ None ☐ Yes. How often per week?	ANY BLOOD ON TISSUE AFTER BOWEL MOVEMENT?: ☐ No ☐ Yes
DID YOU EXPERIENCE ANY BOWEL ISSUES AS A CHILD ☐ No ☐ Yes. Please describe:	
FECAL LEAKAGE: ______ # episodes per ☐ Day ☐ Week ☐ Month	CAUSE OF LEAKAGE: ☐ N/A ☐ Yes. Explain:
FECAL LEAKAGE AMOUNT: ☐ None ☐ Smear ☐ Diarrhea ☐ Few "Pebbles" ☐ Full Stool	
FORM OF PROTECTION: ☐ None ☐ Yes. What type of pad?:	# PAD CHANGES REQUIRED IN 24 HOURS:

LIFESTYLE / QUALITY OF LIFE / FUNCTIONAL LIMITATIONS

SOCIAL ACTIVITIES: ☐ Unaffected ☐ Yes. Explain:
DIET/FLUID INTAKE: ☐ Unaffected ☐ Yes. Explain: CURRENT DIET:
PHYSICAL ACTIVITY: ☐ Unaffected ☐ Yes. Explain: CURRENT PHYSICAL ACTIVITY:
WORK: ☐ N/A ☐ Unaffected ☐ Yes. Explain: CURRENT JOB:
OTHER (SPECIFY): ☐ N/A ☐ Yes. Explain:
PATIENT GOALS:

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL ME??

____

____

____

____

____