Capitol Physical Therapy

Intake Form

Date:_____

Are you a former CPT patient or a friend/family member of a former patient? ☐ Yes ☐ No

I. Personal Information

Name: _____ Address: _____

Home Phone: (___) _____ Cell Phone: (___) _____ May we leave a message? Yes No

DOB: _____/_____/_____ Age:_____ Sex: Male / Female Marital Status: S / M / D / W

Work Phone: (____) _____ E-mail: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relation: _____ Phone: (____) _____

Tobacco use: Yes No Alcohol use: Yes No Vitamin D supplement: Yes No

Describe your usual exercise routine:_____

Primary Insured: _____ DOB: ___/____/_____ Employer: _____

Are you a former Capitol PT patient? Yes No A friend/family member/colleague of a former patient? Yes No

II. Current Symptoms

Problem(s) you are here for: _____

What date (roughly) did your symptoms start? _____

What do you think started your symptoms? _____

Are your symptoms related to a work injury? Yes No Or a motor vehicle accident? Yes No

Symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

☐ Come and go ☐ Constant ☐ Constant, but change with activity

Treatments so far for this problem (injections, chiropractic, etc.): _____

Have you had an X-ray, MRI, or other imaging for this problem? Yes No

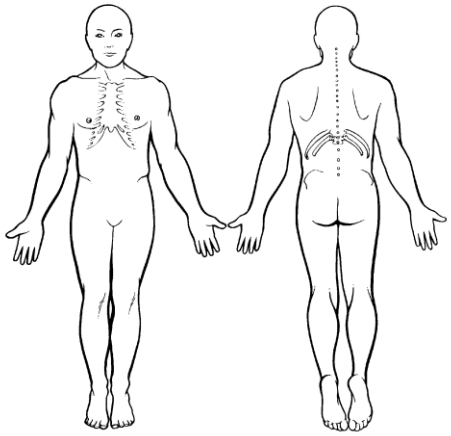
If yes, please list, including date: _____

Have you ever had this before? Yes No If yes, when and how it was treated: _____

What is your personal goal for therapy? _____

Body chart:

- Please mark **all** areas where you feel symptoms on the chart to the right



What makes your symptoms **better**? _____

_____

What make your symptoms **worse**?

How are you able to sleep at night? Fine Moderate difficulty Only with medication

On the scale below, please mark the number which best represents the severity of your pain over the past 24 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

SINCE YOUR SYMPTOMS BEGAN, have you noticed any of the following?

(Check all that apply)

- ☐ **None of these apply to me**
- ☐ Fatigue
- ☐ Generalized muscle weakness
- ☐ Pain at night
- ☐ Leg swelling
- ☐ Weight loss/gain
- ☐ Difficulty maintaining balance when walking
- ☐ Changes in bowel or bladder function
- ☐ Changes in cognition
- ☐ Numbness or tingling
- ☐ Falls
- ☐ Shortness of breath
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Heart palpitations
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Fainting
- ☐ Cough
- ☐ Chest pain especially with sweats
- ☐ Skin changes
- ☐ Other

III. Medical History: Have you ever been diagnosed with or do you have any of the following conditions?

(Check all that apply)

- ☐ **None of these apply to me**
- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ Circulation problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Chemical dependency (i.e. alcoholism)
- ☐ Depression
- ☐ Anxiety
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Sexually transmitted disease/ HIV
- ☐ Rheumatoid Arthritis
- ☐ Arthritis
- ☐ Bladder/urinary tract infection
- ☐ Kidney problems/infection
- ☐ Cholesterol high/low
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Liver problems
- ☐ Allergies/asthma
- ☐ Pacemaker
- ☐ Blood thinners
- ☐ Fibromyalgia
- ☐ Broken bones
- ☐ Recent infection /illness (explain)
- ☐ Other

_____

Past surgical history (list & date): _____

Significant family medical history: _____

During the past month have you been feeling down, depressed, or hopeless? Yes No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes No

Is this something you would like help with? Yes Yes, but not today No

Do you ever feel unsafe at home, or has anyone tried to hit or injure you in any way? Yes No

If you are over 65, how many falls have you had in the last 6 months? _____

Are you taking any medications? Yes No If yes, please list, or add a list you brought along to this paperwork:

Medication name: Amount: Dose:

_____

_____

_____

_____

IV. How did you hear about our clinic?

☐ My doctor's office ☐ I am referring myself for PT ☐ Family/friend/colleague recommended ☐ My insurance company said you were in my network ☐ I did a search on the internet ☐ My trainer ☐ A PT from another company

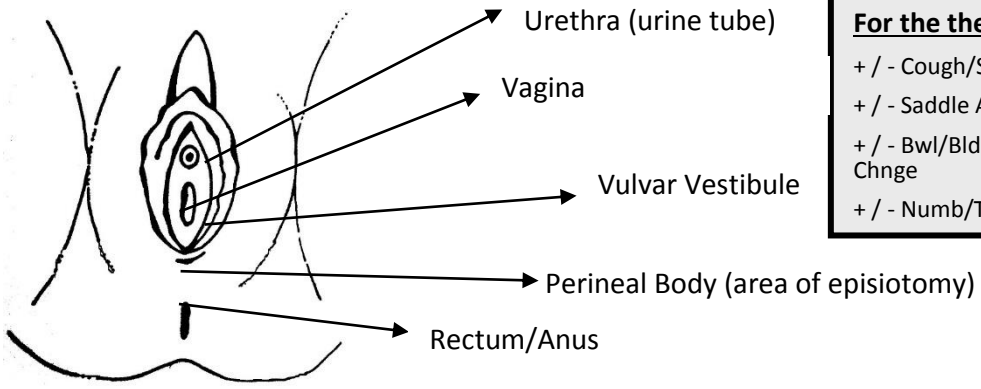
Other:_____

Please tell us who we can thank for sending you our way:_____

Capitol Physical Therapy

FOR FEMALE PELVIC & WOMEN'S HEALTH PATIENTS:

Body Chart: **Please mark the areas where you feel pain**



For the therapist

+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Bldddr Chnge
+ / - Numb/Ting.

CHILDBEARING HISTORY:
Are you pregnant? Y / N If yes, due date?_____
# of pregnancies?_____
# of children?_____# of vaginal deliveries?_____
# of C-sections?_____# of episiotomies?_____
# of forceps deliveries?_____Tearing?_____

GYNECOLOGICAL HISTORY:
Date of last pap smear?_____

History of: (Check all that apply)
☐ Yeast infections? ☐ Candida? ☐ Genital Herpes? ☐ Lichens Simplex? ☐ Urinary tract infections? ☐ Blood in urine?
☐ Do you have any current infections or yeast?
☐ Recent change in vaginal discharge?
☐ Painful menstruation? ☐ If yes, is this new?
Date of last menstrual cycle? _____
Frequency of cycle?_____Length of cycle?_____
Any change in blood flow?_____
Age at menopause? _____ Bleeding since? Y / N / NA

Do you use: (Check all that apply)
☐ Bath salts? ☐ Spermicide? ☐ KY Jelly? ☐ Vaginal lubricants?
☐ Vaginal foams, sprays, or deodorants? ☐ Latex condoms?

URINARY/BLADDER HISTORY: (Check all that apply)
☐ Do you urinate more than one every 2 hours?
☐ Do you have a sense of "urgency" to urinate?
☐ Do you have difficulty initiating urine/hesitancy?
☐ Do you have symptoms of leaking urine?
☐ Do you have interstitial cystitis?
☐ Do you have painful urination?
☐ Recent change in urine color? ☐ Odor?
☐ Wake to urinate? If yes, how many times?_____

BOWEL HISTORY: (Check all that apply)
☐ Do you have irritable bowel syndrome (IBS)?
☐ Do you leak gas or feces?
☐ Do you have constipation?

PELVIC SURGERY HISTORY: (Check all that apply)
☐ Tubal ligation ☐ Gall bladder surgery? ☐ Laparoscopy?
☐ Abdominal or vaginal hysterectomy? ☐ Bladder surgery?
☐ Pelvic surgery? ☐ Vaginal surgery/laser? ☐ Vulvar surgery?

CURRENT SEXUAL ACTIVITY:
☐ Sexually Inactive due to PAIN ☐ Sexually active
☐ Sexually inactive for other reasons

If you are sexually active, continue with this section:
☐ No pain with intercourse
☐Pain with intercourse, able to complete sex
☐ Pain with intercourse disrupts or prevents sex
☐ Pain with intercourse prevents any attempt to have sex
☐ Tolerate manual or oral stimulation only/no penetration

CHECK ALL THE ACTIVITIES THAT CAUSE OR INCREASE PAIN:
☐ Gynecological examination with speculum ☐ Masturbation
☐ Urination after intercourse ☐ Urination in general
☐ Tampon insertion ☐Tampon removal ☐ Wearing pads
☐ Partner manual stimulation ☐ Friction with clothing
☐ Finger insertion into vagina ☐Oral stimulation ☐ Sports activity ☐ Other:_____

CHECK THE WORDS THAT DESCRIBE YOUR PAIN:
☐ Hot ☐ Burning ☐ Scalding ☐ Searing ☐ Sharp ☐ Cutting
☐ Tearing ☐ Tiring ☐ Exhausting ☐ Frightful ☐ Punishing
☐ Grueling ☐ Suffocating ☐ Sickening ☐ Annoying
☐ Troublesome ☐ Miserable ☐ Intense ☐ Unbearable
☐ Discomforting ☐ Other:_____
_____

WHAT MAKES YOUR PAIN BETTER? (Check all that apply)
☐ Heating pad ☐ Ice pack ☐ Resting in bed ☐ Resting in chair ☐ Medication ☐ Cream ☐ Abstaining from sexual intercourse ☐ Not using tampons ☐ Not wearing tight clothes
Other_____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?
____None or:_____
Medication: Y / N Has it helped? Y / N
Surgery? Y / N Did it help? Y / N
Physical Therapy? Y / N

SKIN CONDITIONS: (Check all that apply)
☐ Eczema? ☐ Contact dermatitis ☐ Psoriasis?
☐ Other? _____

FLUID INTAKE: How many of each do you drink every day?
____8 ounce glasses of water ___cans of diet soda ____cans of regular soda ____8 ounce cups of regular coffee
____8 ounce cups of decaffeinated coffee ____8-ounce cups/glasses of tea ____16-ounce cans of beer ____glasses of wine
____glasses of liquor ____8-ounce glasses of milk ____8-ounce glasses of juice Other:_____

Consent to Treatment

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.

2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.

3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.

4. Worker's Compensation - I hereby authorize Capitol Physical Therapy to receive my records related to my work injury.

Photo/Video Authorization

I grant to Capitol Physical Therapy and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

☐ Agree or ☐ Decline

Notice of Privacy Practices

By signing this form, I acknowledge that Capitol Physical Therapy has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Capitol Physical Therapy representatives.

PT Benefits Provided by Your Insurance Company

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Capitol Physical Therapy if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment.

In the unlikely event your account would be turned over to a collection agency you would be responsible for all filing, collection, and legal fees necessary to obtain full recovery of any unpaid balance due CPT. There will also be interest added to invoices with balances over 30 days.

I agree to allow CPT to file my Health Insurance should my worker's compensation, auto, or third party insurance deny the claim, exhaust the benefits, or fail in any want to pay the claim.

Release of Information

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name:	Relationship:

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

Print Patient Name:

_____

Patient or Guardian Signature:

_____

CPT Employee Initial & Date:

_____

Capitol Physical Therapy

APPOINTMENT CANCELLATION POLICY

All appointment cancellations must be made by 12:00 a.m., the night before your scheduled appointment. This can be done either in person, on the phone, or by leaving us a voicemail at the number listed below. If you do not cancel your appointment by 12:00 a.m., or if you do not show for your appointment, you will be charged $25.00 regardless of whether or not you have received reminder(s) from our office.

_____

Signature Date

VERONA CLINIC:	608-848-6628
MOUNT HOREB CLINIC:	608-437-0222
SUN PRAIRIE CLINIC:	608-318-1357
WAUNAKEE CLINIC:	608-850-7275
UNIVERSITY AVE CLINIC:	608-467-3537