



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

(Check all that apply)

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

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 depression or anxiety something you would like help with today?    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?    No    Yes    If yes, please list, or I've attached my own list to this paperwork:

Medication name:	Amount:	Dose:
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Tobacco use:** Yes No    **Alcohol use:** Yes No    **Vitamin D supplement:** 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 problem before? Yes No

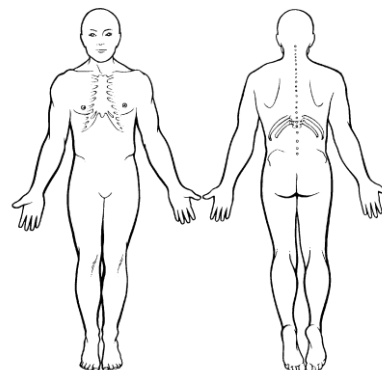
If yes, when and how it was treated: \_\_\_\_\_

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**? \_\_\_\_\_



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)

- Skin changes
- 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
- Other
- None of these apply to me**

Describe your usual exercise routine: \_\_\_\_\_

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

**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 way 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:

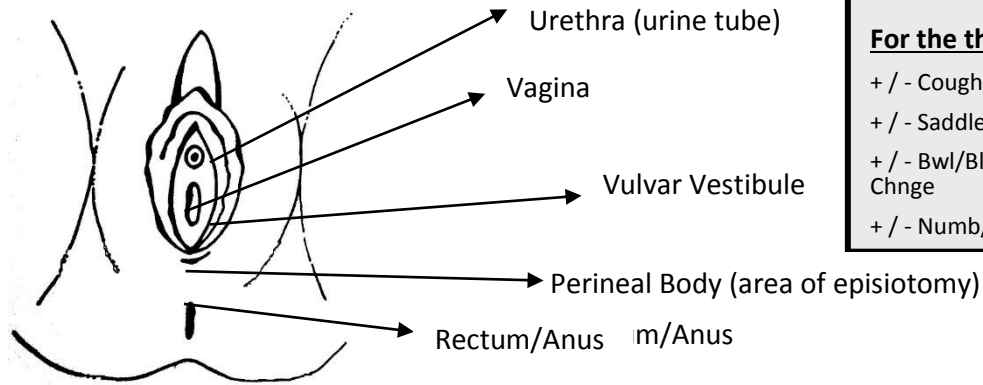
\_\_\_\_\_

CPT Employee Signature \_\_\_\_\_

Date of Authorization: \_\_\_\_\_

# 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/BlDDR 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: \_\_\_\_\_



### 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.

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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