Capitol Physical Therapy

Wisconsin's PRIVATE PRACTICE OF THE YEAR RECIPIENT
Mount Horeb | Verona | at Associated Physicians | University Ave
Waunakee | Sun Prairie
608.848.6628 | capitolphysicaltherapy.com

First Name: ____________ MI: ______ Last Name: ____________ DOB: ____________

Address: ____

CELL HOME — 1st Phone: ____________ CELL HOME — 2nd Phone: ____________ Would you like to receive text reminds For your upcoming appointments? ☐Yes ☐No

Employer: ____________ Email: ____________

Referring Physician: ____________ Injury Type: ____________ Left / Right / Both

Primary Physician Name and Location: ____________

How did you hear about us? ☐Doctor's Office ☐Previous Patient ☐Family/Friend recommended ☐Insurance ☐Internet search ☐Personal Trainer ☐Another PT ☐Other: ____________

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 (Type & 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? ☐Yes ☐No

If yes, please list the medications you are taking **on the next page**, or indicate that you have attached your own list to this paperwork:

Medication name: Amount: Dose:

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

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 related to a work injury? ☐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.):

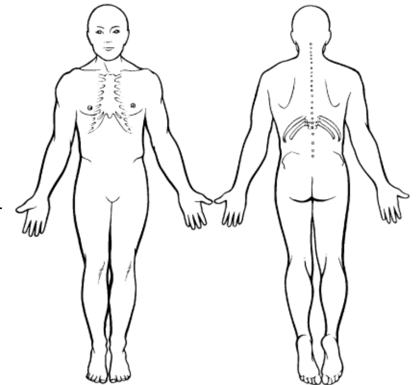
Have you had an X-ray, MRI, or other imaging for this problem? ☐Yes ☐No

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? ______________________________________

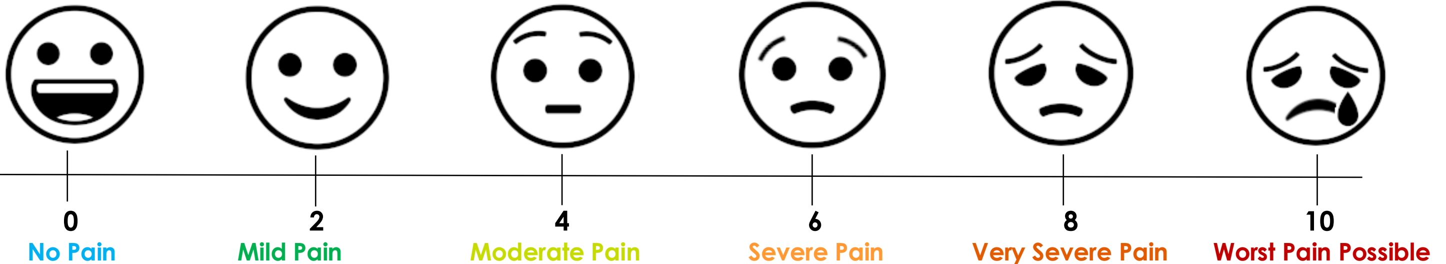


Body chart: Please mark **all** areas where you feel symptoms on the chart to the right

What makes your symptoms **better**? ________________________________

What make your symptoms **worse**? ________________________________

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



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
- ☐ Changes in appetite
- ☐ Heart palpitations
- ☐ Changes in bowel or bladder function
- ☐ Numbness or tingling
- ☐ Falls
- ☐ Shortness of breath
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Headaches
- ☐ Changes in cognition
- ☐ Other
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Fainting
- ☐ Cough
- ☐ Chest pain especially with sweats
- ☐ Difficulty maintaining balance when walking
- ☐ **None of these apply to me**

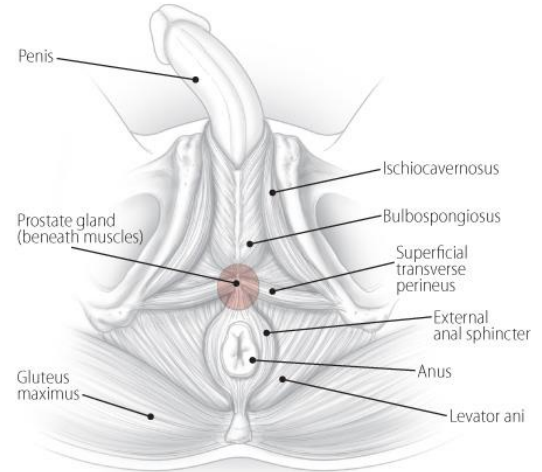
Describe your usual exercise routine:

How are you able to sleep at night?

Patient Signature **Date**

Capitol Physical Therapy

Please mark the areas where you feel pain:



GENITAL REPRODUCTIVE SYSTEM

History of:

- ☐ Genital Herpes?
- ☐ Blood in urine?
- ☐ Current infections?
- ☐ Prostate cancer?
- ☐ Urinary tract or bladder infections?
- ☐ Kidney Stones?
- ☐ Recent change in penile discharge?
- ☐ Benign Prostatic Hypertrophy (BPH)?

Do you use:

☐ Latex condoms ☐ KY Jelly

URINARY/BLADDER HISTORY: (Check all that apply)

Do you:

- ☐ Urinate more than one every 2 hours?
- ☐ Have a sense of "urgency" to urinate?
- ☐ Have difficulty initiating urine/hesitancy?
- ☐ Have symptoms of leaking urine?
- ☐ Have blood in your urine?
- ☐ Have odor?
- ☐ Have painful urination?
- ☐ Have recent changes in urine color?
- ☐ Have Interstitial Cystitis/Painful Bladder?
- ☐ Wake to urinate? If yes, how many times ____________________________

BOWEL HISTORY: (Check all that apply)

Do you:

- ☐ Leak gas or feces?
- ☐ Have irritable bowel syndrome (IBS)?
- ☐ Have constipation?

PELVIC SURGERY HISTORY: (Check all that apply)

Have you had:

- ☐ Laparoscopy?
- ☐ Any pelvic organ surgery?
- ☐ Gall bladder surgery?
- ☐ None

CURRENT SEXUAL ACTIVITY: (Check all that apply)

☐ Sexually Inactive due to PAIN Sexually active Sexually inactive for other reasons

If you are sexually active, continue with this section: (Check all that apply)

- ☐ 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
- ☐ Abnormal discharge
- ☐ Impotence
- ☐ Difficulty with erection
- ☐ Painful ejaculation
- ☐ Cramping pain after ejaculation
- ☐ Blood in semen

CHECK ALL THE ACTIVITIES THAT CAUSE OR INCREASE PAIN: (Check all that apply)

☐ Urination after intercourse ☐ Partner manual stimulation ☐ Friction with clothing
☐ Sports activities ☐ Urination in general ☐ Oral stimulation
☐ Masturbation ☐ Other: ____

CHECK THE WORDS THAT DESCRIBE YOUR PAIN: (Check all that apply)

☐ 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
- ☐ Resting in bed
- ☐ Medication
- ☐ Abstaining from sexual intercourse
- ☐ Ice pack
- ☐ Resting in chair ________________________________
- ☐ Cream ________________________________
- ☐ Not wearing tight clothes ________________________________
- ☐ Other

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? (Check all that apply) None

☐ Medication: ______________________________________ ☐ It has helped ☐ It hasn't helped
☐ Surgery: ______________________________________ ☐It has helped ☐ It hasn't helped
☐ Physical Therapy ______________________________________ ☐It has helped ☐It hasn't helped

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 decaf 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____________________

SKIN CONDITIONS:

Eczema?______________ Contact dermatitis?___________ Psoriasis?_____________ Other? ________________________________

____

Patient Signature **Date**

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 Signature

____
Date of Authorization

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 608-848-6628

MOUNT HOREB 608-437-0222

SUN PRAIRIE 608-318-1357

WAUNAKEE 608-850-7275

UNIVERSITY AVE 608-467-3537