ONONDAGA PHYSICAL THERAPY
helping you live, work and play better

Registration Form
(Please Print Clearly)

PATIENT INFORMATION

TODAY'S DATE: / / PRIMARY CARE PHYSICIAN:

Patient's Last Name	First	Middle	What would you prefer to be called?

Street Address	City	State	Zip Code

Home Phone	Work Phone (extension)	Cell Phone	Sex	Age	Date of Birth
			□ Male □ Female		/ /

Email Address:	How would you like us to keep in touch with you?
	□ Email □ Postal Mail

Marital Status	Employment Status	Accident?	Date Of Next Physician Appt
□ Single □ Married □ Widowed □ Divorced	□ Full □ Part □ Retired □ Not Employed □ Other	□ None □ Auto □ Work □ Other	/ /

INSURANCE INFORMATION (Please Show Your Insurance Cards)

Primary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #

Patient Relationship To Policy Holder: □ Self □ Spouse □ Child □ Other_____

Secondary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #

Patient Relationship To Policy Holder: □ Self □ Spouse □ Child □ Other_____

IN CASE OF EMERGENCY

Contact Name	Relationship To Patient	Home Phone	Cell Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Onondaga Physical Therapy, LLC. I understand that I am financially responsible for any balance that is unpaid by my insurance company. I understand Onondaga Physical Therapy will impose a late fee of $25 for any balance that is older than 90 days, unless I have prior payment arrangements. I further authorize Onondaga Physical Therapy, LLC and my insurance company to release any information that is required to process my claims.

I hereby consent to treatment procedures and patient care which in the judgment of my therapist and/or physician may be considered necessary or advisable while I am a patient of Onondaga Physical Therapy, LLC.

I hereby authorize the use or disclosure of my individually identifiable health information as described in the NOTICE OF PRIVACY PRACTICES I received.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

ONONDAGA
PHYSICAL THERAPY
helping you live, work and play better

Medical History Form

(Please Print Clearly)

Name:	Date:

Have you EVER been diagnosed as having any of the following conditions?

Yes No Heart Problems	Yes No Epilepsy / Seizures	Yes No Implanted Devices
Yes No High Blood Pressure	Yes No Hearing Loss / Disorder	Yes No Cancer
Yes No Pacemaker	Yes No Eye Disease	Yes No Osteoporosis
Yes No Rheumatoid Arthritis	Yes No Muscular Disease / Disorder	Yes No Depression
Yes No Other Arthritic Condition	Yes No Multiple Sclerosis	Yes No Past Pregnancy
Yes No Stroke	Yes No Tuberculosis	Yes No Currently pregnant
Yes No Lung Disease	Yes No Circulation Problems	Yes No Chemical Dependency
Yes No Asthma	Yes No Hepatitis	Yes No Other:
Yes No Diabetes	Yes No Kidney Disease	

Please list any surgeries or other medical conditions for which you have been treated

Date	Surgery/Injury/Condition	Reason:

List all medications you are currently taking (pills, injections, inhalers, skin patches):

Any additional comments or information you would like us to know:

X _____

PATIENT/GUARDIAN SIGNATURE DATE

ONONDAGA PHYSICAL THERAPY
helping you live, work and play better

HIPAA Privacy Information

TODAY'S DATE: / /

PATIENT INFORMATION

Patient's Last Name First Name Date of Birth

CONTACT METHODS

Please check the appropriate boxes indicating acceptable ways for us to contact you regarding either your appointment(s) or other medical information. By checking these boxes, you give us permission to contact you and/or leave messages.

Appointment Information	Medical Information
□ Home Phone	□ Home Phone
□ Mobile Phone	□ Mobile Phone
□ Mobile Text**	□ Mobile Text**
□ Work Phone	□ Work Phone
□ With another person:	□ With another person:
□ Send Via Mail	□ Send Via Mail
□ Send Via Email	□ Send Via Email

**Checking the Mobile Phone box will enroll you in Text Message Appointment Reminders. Messages are an automated reminder only and are delivered the night before your appointments with us. Carrier messaging rates apply per your plan.

If you have authorized us to communicate medical or appointment information with another individual, please provide their name and relationship:

Name: _____ Relationship: _____

AGREEMENT INFORMATION

I have read the above information and have authorized Onondaga Physical Therapy to relay appointment or medical information in the manners I have specified above.

x _____

PATIENT SIGNATURE DATE

ONONDAGA PHYSICAL THERAPY
helping you live, work and play better

Attendance Policy

Onondaga Physical Therapy requires a minimum 24-hour notice when cancelling any appointment

- Cancellations may be submitted via text message or phone call to (315) 635-5000
- It is expected for you to arrive on time to all scheduled appointments. If you arrive more than **10 minutes late,** you will be considered a "no show".
- Text message reminders are a courtesy and should NOT be used as a primary method of tracking your appointments as they are not 100% reliable.

Please be considerate of our other patients - If your **personal or work** schedule might affect your ability to keep your appointment, please don't schedule until you are certain you can keep your time. We do utilize a waiting list so that we can offer cancelled appointment slots to other patients waiting to be treated.

We are sensitive to the fact that an emergency may occur in a rare instance and do offer 1 cancellation per month as a courtesy for these instances.

Late Cancellation (less than 24 hours notice) and No-Show Fees:

- 1st late cancel/No Show per month - Fee Waived
- 2nd late cancel/No Show per episode of care - $25
- 3rd late cancel/No Show per episode of care - $50
- 4th late cancel/No Show per episode of care - $65

(Exceptions may be made for bad weather when schools in our area close or dismiss early as well as travel advisories issued for Onondaga County.)

If you fail to show for an appointment or cancel without speaking to one of us, we will call or text you to remind you of your next appointment. If we do not hear from you by the next morning confirming this appointment, we will **delete all future appointments** opening up opportunities for us to help other patients. Please call to reschedule your appointments.

I agree to abide by the above policy and to pay the above fee PRIOR to my next appointment if I am in violation. I understand these charges will NOT be covered by my insurance company.

X _____

Printed Name **Signature** **Date**

Therapist Reviewed (Initial): _____

Pelvic Floor Therapy Questionnaire

Patient name _____ **Date** _____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____ Number of vaginal deliveries _____

Birth weight of largest baby _____ Number of cesarean deliveries _____

Number of episiotomies _____ Date of last pap smear _____

Did you have any trouble healing after delivery Y N

Do you have a history of sexual abuse or trauma Y N

Are you having regular periods/ menstrual cycles Y N

Do you have frequent urinary tract infections Y N

Pain

Do you have pain with:

Sexual intercourse Y N

Pelvic exam Y N

Tampon use Y N

Back, leg, groin, abdominal pain Y N

Test results

Urodynamics test Y N Results: _____

Cystoscope Y N Results: _____

Urine test Y N Results: _____

Bowel test Y N Results: _____

Bladder symptoms

Do you lose urine when you:

Cough/ sneeze/ laugh	Y	N	Lift/ exercise/ dance/ jump	Y	N
On the way to the bathroom	Y	N	Have a strong urge to urinate	Y	N
Hear running water	Y	N	Other _____	Y	N

Do you wet the bed Y N

Have burning/ pain with urination Y N

Difficulty starting a stream of urine Y N

Strain to empty your bladder Y N

Feel unable to empty bladder fully Y N

Have a falling out feeling Y N

Have pain with a full bladder Y N

Have an urgency of urination
(a strong urge to urinate) Y N

Urinate more than 7 times/day Y N

Bowel symptoms

Strain to have a bowel movement	Y	N	Leak / stain feces	Y	N
Include fiber in your diet	Y	N	Have diarrhea often	Y	N
Take laxatives / enema regularly	Y	N	Leak gas by accident	Y	N
Have pain with bowel movement	Y	N			

Have a very strong urge to move your bowels Y N

How often do you move your bowels: _____ per day, week

Most common stool consistency
____ liquid ___ soft ___ firm ___ pellets ___ other _____

Thank you for taking the time to fill out this questionnaire.

Pelvic Floor Distress Inventory–short form 20

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by putting an **X** in the appropriate box or boxes. While answering these questions, please consider your symptoms over the **last 3 months.**

The PFDI-20 has 20 items and 3 scales.
All items use the following format with a response scale from 0 to 4.

Do you _____?

☐ No; ☐ Yes
0

If yes, how much does it bother you?

☐ 1 ☐ 2 ☐ 3 ☐ 4
Not at all Somewhat Moderately Quite a bit

Scales
Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6):

1. Usually experience *pressure* in the lower abdomen?
2. Usually experience *heaviness or dullness* in the pelvic area?
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?
5. Usually experience a feeling of incomplete bladder emptying?
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?

Colorectal-Anal Distress Inventory 8 (CRADI-8):

7. Feel you need to strain too hard to have a bowel movement?
8. Feel you have not completely emptied your bowels at the end of a bowel movement?
9. Usually lose stool beyond your control if your stool is well formed?
10. Usually lose stool beyond your control if your stool is loose?
11. Usually lose gas from the rectum beyond your control?
12. Usually have pain when you pass your stool?
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?

Urinary Distress Inventory 6 (UDI-6):

15. Usually experience frequent urination?
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?
17. Usually experience urine leakage related to coughing, sneezing, or laughing?
18. Usually experience small amounts of urine leakage (that is, drops)?
19. Usually experience difficulty emptying your bladder?
20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?

Scale scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PFDI –20 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).

Scoring of PFDI-20 (POPDI-6 + CRADI-8 + UDI-6)

POPDI-6

#	no = 0	not at all = 1	somewhat = 2	moderately = 3	quite a bit = 4
1					
2					
3					
4					
5					
6					

Total scores = ____ divide by 6 = _____ x 25 = _____

CRADI-8

#	no = 0	not at all = 1	somewhat = 2	moderately = 3	quite a bit = 4
7					
8					
9					
10					
11					
12					
13					
14					

Total scores = ____ divide by 8 = _____ x 25 = _____

UDI-6

#	no = 0	not at all = 1	somewhat = 2	moderately = 3	quite a bit = 4
15					
16					
17					
18					
19					
20					

Total scores = ____ divide by 6 = ____ x 25 = ____

POPDI-6 score _____
CRADI-8 score _____
UDI-6 score _____

Add all scores for PFDI-20 score = _____ Higher = more dysfunction

Barber MD, Kuchibhatla M, Pieper CF, Bump RC. Psychometric evaluation of 2 comprehensive condition-specific quality of life instruments for women with pelvic floor disorders. American Journal of Obstetric and Gynecology Volume 185; Number 6, 2001

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

I understand that in order for 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 program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I have the option of having a second person present in the room during the procedure and _____ choose _____ refuse this option.

Date: _____ Patient Name: _____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature