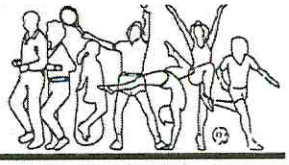
HANSEN PHYSICAL THERAPY

- Personal
- Professional
- Experienced Physical Therapy



50 E. Minnesota St. Ste. 2, Rapid City, SD 57701 • Phone (605) 342-3110 • Fax (605) 342-3120 • www.hansenphysicaltherapy.com

Patient Information	Last Name:	First Name:	Middle Name:
	Street Address:	City, State & Zip	
	E-mail Address:	Social Security Number:	
	Home Phone:	Work Phone:	Cell Phone:
	Date of Birth:	Gender: Male Female	
	Patient Status: Single Married	Divorced Widowed Partner Legally Separated	
	Emergency Contact:	Relationship:	Phone:
	Employer/School Name:	Phone:	
	Address:	Job Description:	Are you a student?
	How did you hear about us?		
Responsible Party	Person responsible for the bill (only if different than Patient): Last:	First:	
	Date of Birth:	Social Security Number:	Phone:
	Address of Person Responsible:	City, State & Zip:	
	Employer of Person Responsible:	Relationship to Patient:	

Insurance Information	**Primary Medical Insurance**	**Secondary Medical Insurance**
	Insurance Co. Name:	Insurance Co. Name:
	Policy Holder's Name:	Policy Holder's Name:
	Policy ID Number:	Policy ID Number:
	Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
	Policy Holder's Social Security #:	Policy Holder's Social Security #:
	Policy Holder's Relationship to Patient:	Policy Holder's Relationship to Patient:

Reminders	Would you like appointment reminders? ☐ Yes ☐ No
	If yes, please check how you would like to be contacted: ☐ Email ☐ Text *** Standard messaging rates apply**
	Cell phone carrier:
	☐ I consent to all communication, including but not limited to communication about my medical condition and advice from Physical Therapist by the following means: ☐ Email ☐ Text
	☐ I do not consent to any email or texting communication.

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Hansen Physical Therapy. I further authorize assignee to obtain my plan provisions to act as authorized representative on my behalf on insurance claims. I authorize the use of this signature on all my insurance and/or employee health benefits claim submission. I understand that I am financially responsible for all charges whether or not paid by said insurance. This order will remain in effect until revoked by me in writing. I hereby authorize said assignee to release all information, including medical record copies, necessary to secure payment and to complete disability forms presented to me. In response to any reasonable request of cooperation, I agree to cooperate with Hansen Physical Therapy in any attempts by Hansen Physical Therapy to pursue such claim, choose action or right against my insurers and/or employees health care plan.

_____ _____

Signature of Patient or Guardian Date

Authorization for the Use and Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, Hansen Physical Therapy may not use or disclose your health information to anyone without your authorization, except as provided in our Notice of Privacy Practice. Your signature on the following section indicates that you are giving permission for the uses and disclosures described herein. I,_____ , (print patient name or name of minor child) hereby authorize and request the use and disclosure of all the health information that pertains to me. I authorize and request Hansen Physical Therapy to make these disclosures of my health information. I authorize and request the following persons to receive these disclosures of my health information and elect not to provide statement of purpose for the use of the disclosure to the following persons (please print):

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer be protected. I understand that this authorization will automatically expire on December 31, 2021, but that I may revoke this authorization at any time by signing the revocation form and returning it to Hansen Physical Therapy. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

_____ _____
Signature of Patient or Guardian Date

Communication Consent: Patients/Clients frequently request that we communicate with them by email or text. Hansen Physical Therapy respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur.

Since email and texting are insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us.

Further examples of communication include: exercises, imaging reports, diagnostic's studies, response to treatment and follow-up care. We will not send out personally indefinable information such as Social Security number, date of birth, insurance information or personal address.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information.

Hansen Physical Therapy will not be responsible for any privacy or security breaches that may occur through email or text communications that you have consented to. You may choose to limit the type of email or text communication to decrease your risk of exposing your protected health information to unauthorized persons.

Payment for Service Is Expected at Each Visit*: This includes deductibles, co-insurance, co-payments, and treatment or supplies not covered by insurance. The following methods of payment are accepted: cash, checks, or credit. This section does not apply to workers compensation patients. If your account becomes delinquent, collection proceedings will occur, and you will be 100% liable for any collection fees, reasonable attorneys' fees, and court costs incurred by the Hansen Physical Therapy to collect said fees from the responsible party.

Cancellation Policy *: If it is necessary to cancel an appointment, please call our office 24 hours in advance during business hours to cancel. If you feel ill, wary of road conditions or an emergency should arise please contact us as soon as possible. Our policy is to charge a cancellation fee of $40.00 for **three consecutive missed appointments** as a no-show fee. Hansen Physical Therapy wants you to get the maximum results from treatment and this means attending your appointments on a regular basis.

Notice of Privacy Practices*: Your signature below indicates that you have been made aware of our privacy practice. A copy will be provided to you upon your request. In addition, the undersigned patient or responsible party acknowledges that they have read and agrees to the information provided.

I have read and understand the above polices.

***See our "Appointment & Payment Agreement Form "and "Notice of Privacy Practices" for more information**

_____ _____

Signature of Patient or Guardian Date

Minor Consent Form

As the Parent/Guardian to _____, a minor, I am authorizing the following.
Please initial in the provided blanks to those that you are authorizing.

1. I authorize _____ , a minor, to be seen and treated without a parent or guardian present.
2. I authorize _____ , a minor, to been seen and treated at Hansen Physical Therapy when accompanied only by the following adult, friend, childcare provider etc.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Signature of Parent or Guardian Date

Medical History

Name: _____ **Today's Date:** _____
Onset/Injury Date: _____ **Surgery Date:** _____
Referring Physician: _____ **Next Doctors Appt:** _____
Is this: Work related? Employer _____ **Auto Related?** _____ **State:** _____
Describe your current condition and how it began:

_____

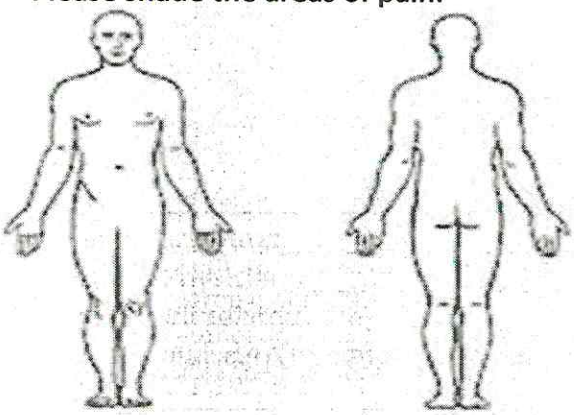
_____

Have you had any tests for this condition? ☐ X-ray ☐ MRI ☐ Injections ☐ CT scan:
If yes date: _____ **Office:** _____

How is your condition changing?
☐ Improving ☐ No change ☐ Decreasing

In the past week, how much has your pain interfered with your daily activities? (I.e. Household chores, work, social activities, etc.) 0 1 2 3 4 5 6 7 8 9 10 Unable

Please shade the areas of pain:



Pain: Where? _____
What makes the pain worse? _____
What makes the pain better? _____
Numbness: YES/NO, where: _____
What increases numbness? _____
What decreases numbness? _____

Rate your current pain on a scale of 0 -10 (0 = no pain/discomfort, 10 = worst pain imaginable) _____
Rate your pain at its best _____ **Rate your pain at its worst** _____

Circle the nature of your pain: Sharp Achy Numb Burning Throbbing Shooting

How often are your symptoms present?
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% if the day) ☐ Intermittently (0-25% of the day)

In general, how is your overall health right now:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please check all of the following that apply:
☐ Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Stroke
☐ Epilepsy ☐ Pacemaker ☐ Dizziness/ Fainting ☐ Back Injury
☐ Fracture ☐ Arthritis ☐ Cancer ☐ Bladder Problems
☐ Currently Pregnant: # Weeks____ ☐ Other: _____

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Pelvic Floor History Form
Physical Therapy

NAME _____

CHIEF COMPLAINT

Describe the current problem that brought you here.

When did this problem begin? _____ months ago _____ years ago

Since the onset, is your problem: Better Worse Same

Was your first episode of the problem related to a specific incident? Yes No

Date of incident _____
Describe incident.

Rate the severity of this problem.

0 1 2 3 4 5 6 7 8 9 10
No problem Major problem

Rate your pain.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain

Describe the nature of your pain (i.e. constant burning, intermittent ache, etc).

Describe how your lifestyle/quality of life been altered/changed by this problem? Please specify.

Physical activity:

Social activities:

Diet/Fluid intake:

Work:

Other:

Describe what relieves your symptoms.

Describe previous treatments/exercises.

What are your treatment goals/concerns?

Circle activities that cause or aggravate your **PAIN**. *If not applicable please go to next section.*

- Sitting more than ___ minutes
- Walking more than ___ minutes
- Standing more than ___ minutes
- Changing positions (i.e. sit-to-stand)
- Light activity (light housework)
- Vigorous activity/exercise (run/weight lift/jump)
- Sexual activity
- With cough/sneeze/straining
- With lifting/bending
- No activity affects my pain

Other, please list _____

Circle activities that cause or worsen your **LEAKING**.

- Constant leakage
- Sitting more than ___ minutes
- Walking more than ___ minutes
- Standing more than ___ minutes
- Changing positions (rolling, sit to stand)
- Light activity (walking, light housekeeping)
- Vigorous activity/exercise (running, weight lifting)
- Walking to the toilet
- Strong urge to go
- Sexual activity
- With cough/sneeze/straining
- With lifting/bending
- With laughing/yelling
- With cold weather
- With triggers – running water/key in door
- With nervousness/anxiety
- No activity affects my leakage

Other, please list _____

EMPLOYMENT HISTORY

Occupation: _____

Hours/week: _____

Missed work due to this problem? Yes No

HEALTH HISTORY

General Health:	Excellent	Good	Average	Fair	Poor
Mental Health:	Excellent	Good	Average	Fair	Poor
Current level of stress:	High	Med	Low		

Date of last physical exam: _____
Tests performed (please list):

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Type:

Circle any of the following conditions or diagnoses that apply to you.

- Allergies – list below
- Cancer
- Childhood bladder problems
- Chronic fatigue syndrome
- Depression
- Diabetes
- Epilepsy/Seizures
- Emphysema/Chronic bronchitis
- Fibromyalgia
- Headaches
- Heart problems
- Hepatitis
- High blood pressure
- HIV/AIDS
- Irritable bowel syndrome
- Joint replacement
- Kidney disease
- Latex sensitivity
- Low back pain
- Multiple sclerosis
- Osteoarthritis
- Osteoporosis
- Pelvic pain
- Physical or sexual abuse
- Rheumatoid arthritis
- Sacroiliac/Tailbone pain
- Sexually transmitted disease
- Stroke
- Thyroid problems
- TMJ/Neck pain

Other/Describe: _____

Have you had any of these symptoms in the past 6 months?

Yes	No	Fever/Chills
Yes	No	Unexplained weight change
Yes	No	Dizziness or fainting
Yes	No	Change in bowel or bladder functions
Yes	No	Malaise (Unexplained tiredness)
Yes	No	Unexplained muscle weakness
Yes	No	Night pain/Sweats
Yes	No	Numbness/Tingling

Circle all areas in which you have had surgeries or procedures.

Back/Spine	Bladder/Prostate
Brain	Bones/Joints
Female organs	Abdominal organs

Please provide date and type for all procedures circled above.

Medications (pills, injection, patch) Start Date Reason

_____

_____

_____

_____

Over-the-counter vitamins, etc Start Date Reason

_____

_____

_____

_____

BLADDER HEALTH

Indicate your average fluid intake (one glass is 8 oz or one cup) _____ glasses/day
Of this total how many glasses are caffeinated? _____ glasses/day

How often do you urinate?
Awake hours: _____ times/day Sleep hours: _____ times/night

Circle the typical amount of urine passed per urination: Small Medium Large

Indicate yes or no below in regards to your bladder habits.

Yes No Sensation that you need to go to the toilet?
If yes, how long can you delay the urge before you have to go to the toilet? _____minutes, _____hours, _____not at all

Yes No Urinate frequently BEFORE you have the urge to urinate?

Yes No Do "triggers" make you feel like you can't wait to go to the toilet?
If yes, describe (ie. running water)_____

Yes No Trouble making it to the toilet in time when you have the urge?

Yes No Take your time to go to the toilet and empty your bladder?

Yes No Difficulty initiating the urine stream?

Yes No Can you stop the flow of urine when on the toilet?

Yes No Slow/hesitant/intermittent urinary stream?
Yes No Strain to pass urine?
Yes No Pain when you urinate?
Yes No Blood in your urine?
Yes No Dribble after urination?
Yes No Feel your bladder is still full after urinating?
Yes No Have you had any bladder infections in the last year?
If yes, how many? _____Date of last infection? _____
If yes, treatment received? _____

Circle the form of protection you wear.

None	Pantyshields	Maxipads	Diaper
Tissue paper	Minipads	Specialty product	Other_____

On average, how many pad/protection changes are required in 24 hours for urine leakage?
_____# of pads

Bladder leakages

Number of episodes
___ Not applicable
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/cough
___ Constant

On average, how much urine do you leak?
___ Not applicable
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

BOWEL HEALTH

How often do you have a bowel movement?
_____ times/day _____ times/week

Circle the consistency of your stool: Hard Loose Normal

Indicate yes or no in regards to your bowel habits.
Yes No Sensation that you need to have a bowel movement?
If yes, how long can you delay the urge before you have to go to the toilet? _____ minutes, _____ hours, _____ not at all
Yes No Ignore the urge to defecate?
Yes No Trouble making it to the toilet on time when you have an urge?
Yes No Strain to have a bowel movement?
If yes, how often? _____ % of the time
Yes No Pain when you defecate (have bowel movement)?
Yes No Leak gas?
Yes No History of constipation?
If yes, what are your management techniques?_____

Circle the form of protection you wear.

None	Pantyshields	Maxipads	Diaper
Tissue paper	Minipads	Specialty product	Other_____

On average, how many pad/protection changes are required in 24 hours for bowel leakage?

_____ # of pads

Bowel leakages

Number of episodes

___ Not applicable
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge
___ Constant

How much stool do you lose?

___ Not applicable
___ No leakage
___ Stool staining
___ Small amount in underwear
___Complete emptying

OBSTETRIC & GYNECOLOGIC HISTORY *If not applicable please go to next section.*

Indicate yes or no below

Yes No Vaginal dryness
Yes No Regular periods.
How frequent? _____
If no, why?_____
Yes No Painful periods.
Yes No Menopause.
If yes, when? _____
Yes No Painful vaginal penetration.
Yes No Pelvic pain.
Yes No Prolapse or organ falling out.
If yes, circle all that apply:
Only with menstruation
With standing for ____ minutes or _____ hours
With exertion or straining
At the end of each day
Present all day

Describe other obstetric or gynecologic history not listed above.

CHILDBIRTH HISTORY

Indicate yes or no below.

Yes No Pregnancies. #_____

If no, please disregard remaining questions.

Yes No Childbirth vaginal deliveries. #_____

Yes No Episiotomy. #_____

Yes No Painful episiotomy scar.

Yes No C-section. #_____

Yes No Difficult childbirth. #_____

Yes No Labor trauma.

If yes, describe: _____

Indicate birth weights/dates of babies.

Date	Weight
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

SEXUAL HISTORY

Indicate yes or no below.

Yes No History of sexual abuse.

Yes No Sexually active.

Yes No Pain with intercourse.

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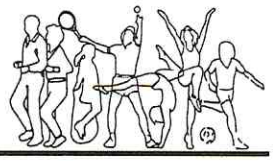

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PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

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 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, postural restoration 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 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 procedure.
4. Second person in room.

   _____ I choose to have a second person present in the room during the examination

   _____ I decline having a second person present in the room during the examination.

   _____ I am okay with a student OBSERVING during the examination.

_____
Patient Name

_____ _____
Patient signature Date

_____ _____
Signature of patient or Guardian (if applicable) Date

_____ _____
Physical Therapist signature Date