HIGH POINTE
therapy at The Women's Hospital

EVAL DATE:

PATIENT INFORMATION

LAST NAME	FIRST	MI

ADDRESS (STREET, CITY, STATE ZIP)	SSN	DOB

HOME PHONE	WORK PHONE EXT.	CELL PHONE

IS INJURY RELATED TO: ☐ WORK ☐ AUTO ☐ OTHER IF WORK, COMPLETE WORK RELATED INJURY INFORMATION BELOW.
IS A HOME HEALTH AGENCY CURRENTLY PROVIDING NURSING SERVICES IN YOUR HOME? ☐ YES ☐ NO
HAVE YOU HAD ANY THERAPY SERVICES IN THE LAST 12 MONTHS? ☐ YES ☐ NO

EMERGENCY CONTACT NAME	**RELATIONSHIP**	**PHONE NUMBER**

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME (PARENT/GUARDIAN/OTHER, WHO BROUGHT MINOR FOR THERAPY)

RELATIONSHIP TO PATIENT	DATE OF BIRTH	SSN

ADDRESS (STREET, CITY, STATE ZIP)

HOME PHONE	WORK PHONE EXT	CELL PHONE

WORK RELATED INJURY

EMPLOYER NAME:	CASE MANAGER NAME:	CASE MANAGER PHONE:

EMPLOYER ADDRESS (STREET, CITY, STATE ZIP)	CASE MANAGER FAX:

EMPLOYER LIABILITY CARRIER	LIABILITY CARRIER ADDRESS

DATE OF INJURY	CLAIM #:	NUMBER OF VISITS APPROVED:

TO BE COMPLETED BY OFFICE

IS THE PATIENT THE SUBSCRIBER? ☐ YES ☐ NO	IF NO, THEN: SUBSCRIBER/ POLICYHOLDER NAME:	DOB

SUBSCRIBER/POLICYHOLDER ADDRESS (IF OTHER THAN PATIENT):

PRIMARY INSURANCE	**ID #**	**GROUP #**

INSURANCE EFFECTIVE DATE:	PRE-CERT REQUIRED: ☐ YES ☐ NO
PERSON QUOTING BENEFITS:	PRE-CERT CONTACT:

DEDUCTIBLE AMOUNT:	DEDUCTIBLE AMOUNT MET:	PRE-CERT INFORMATION:
COPAY $:	COINSURANCE %:	
OUT OF POCKET AMOUNT:	OUT OF POCKET AMOUNT MET:	DOES PRE-EXISTING APPLY? ☐ YES ☐ NO

LIMITATIONS/EXCLUSIONS:

CLAIMS MAILING ADDRESS:	PHONE:

INFORMED CONSENT

I consent to treatment rendered by HighPointe Therapy Services at the Women's Hospital as ordered or approved by my physician. I agree to participate in the therapy program to the best of my ability to facilitate recovery.

AUTHORIZATION FOR DISCLOSURE

I, a patient of High Pointe Therapy Services at the Women's Hospital, give my expressed permission to discuss with the individual(s) I have listed:

Please check appropriate box(es): ☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name:_____ Relationship: _____Phone:(____)_____
Name:_____ Relationship: _____Phone:(____)_____
Name:_____ Relationship: _____Phone:(____)_____

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

A confidential message (i.e.: appointment reminders) may be left on your telephone answering machine or voicemail.
If you would like to receive these calls at an alternate number, please list: (_____)_____

PATIENT/GUARANTOR SIGNATURE DATE

PATIENT NAME:

_____

DATE OF BIRTH: _____
Month Day Year

SEX: ☐ **Male** ☐ **Female**

RACE
☐ Asian
☐ Native Hawaiian/ Pacific Islander
☐ Black
☐ White

ETHNICITY
☐ Hispanic or Latino
☐ Not Hispanic or Latino

LANGUAGE
☐ English understood?
☐ Interpreter needed?
☐ Language you speak most often: _____

EDUCATION:
Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12
☐ Some college / technical school
☐ College graduate
☐ Graduate school / advanced degree

SOCIAL HISTORY:
Cultural/Religious
Any customs or religious beliefs or wishes that might affect care?

_____

With whom do you live?
☐ Alone ☐ Spouse only
☐ Spouse and other(s) ☐ Child (not spouse)
☐ Other relative(s) (not spouse or children)
☐ Group setting ☐ Personal care attendant
☐ Other: _____

Have you completed an advance directive?
☐ Yes ☐ No

Who referred you to the physical therapist?

_____

Employment / Work (Job/School/Play)
☐ Working full-time outside home
☐ Working part-time outside home
☐ Working full-time from home
☐ Working part-time from home
☐ Homemaker ☐ Student ☐ Retired ☐ Unemployed
Occupation:_____
Employer: _____

LIVING ENVIRONMENT:
Does Your home have:
☐ Stairs, no railing
☐ Stairs, railing
☐ Ramps
☐ Elevator
☐ Uneven terrain
☐ Assistive devices (eg, bathroom): _____
☐ Any obstacles: _____

Do you use:
☐ Cane
☐ Walker or rollator
☐ Manual wheelchair
☐ Motorized wheelchair
☐ Glasses, hearing aids
☐ Other: _____
_____
_____

Where do you live?
☐ Private home ☐ Private apartment
☐ Rented Room ☐ Board & care/assisted living/group home
☐ Homeless (with or without shelter)
☐ Long-term care facility (nursing home) ☐ Hospice
☐ Other:_____

Do you have any sensitivity to latex that you are aware of?
☐ Yes ☐ No

TODAY'S DATE: _____

GENERAL HEALTH STATUS:
At the present time would you say your health is:
☐ Excellent ☐ Very Good ☐ Fair ☐ Poor
Have you had any major life changes during past year? (eg, new baby, job change, death of a family member? ☐ Yes ☐ No

SOCIAL / HEALTH HABITS:
Smoking:
1. Currently smoke tobacco? ☐ Yes ☐ Cigarettes # packs per day ___
☐ Cigars/Pipes # per day ___
☐ No
2. Smoked in the past? ☐ Yes: **Year Quit:** _____ ☐ No

Alcohol:
1. How many days per week do you drink beer, wine, or other alcoholic beverages, on average? _____
2. If one beer, one glass of wine, or one cocktail equals one drink how many drinks do you have, on an average day? _____

Exercise:
Do you exercise beyond normal daily activities and chores?
☐ Yes. Describe the exercise: _____
On average how many days per week do you exercise or do physical activity? _____
For how many minutes, on an average day? _____
☐ No.

FAMILY HISTORY:
(Indicate whether mother, father, brother/sister, aunt/ uncle, or grandmother/grandfather, and age of onset if known):
☐ Heart disease _____
☐ Hypertension _____
☐ Stroke: _____
☐ Diabetes: _____
☐ Cancer: _____
☐ Psychological: _____
☐ Arthritis: _____
☐ Osteoporosis: _____
☐ Other: _____

MEDICAL / SURGICAL HISTORY:
Please check if you have ever had:
☐ Arthritis ☐ Multiple sclerosis
☐ Broken bones / fractures ☐ Muscular dystrophy
☐ Osteoporosis ☐ Parkinson disease
☐ Blood disorders ☐ Seizures / epilepsy
☐ Circulation/vascular problems ☐ Allergies
☐ Heart problems ☐ Developmental/growth problems
☐ High blood pressure ☐ Thyroid problems
☐ Lung problems ☐ Cancer
☐ Stroke ☐ Infectious disease (e.g. hepatitis)
☐ Diabetes / high blood sugar ☐ Kidney problems
☐ Low blood sugar/hypoglycemia ☐ Repeated infections
☐ Head injury ☐ Ulcers / stomach problems
☐ Depression ☐ Skin diseases
☐ Other: _____

Within the past year, have you had any of the following symptoms? (Please check all that apply)
☐ Chest pain ☐ Difficulty sleeping
☐ Heart palpitations ☐ Loss of appetite
☐ Cough ☐ Nausea / vomiting
☐ Hoarseness ☐ Difficulty swallowing
☐ Shortness of breath ☐ Bowel problems
☐ Dizziness or blackouts ☐ Weight loss / gain
☐ Coordination problems ☐ Urinary problems
☐ Weakness in arms or legs ☐ Fever / chills / sweats
☐ Loss of balance ☐ Headaches
☐ Difficulty walking ☐ Hearing problems
☐ Joint pain or swelling ☐ Vision problems
☐ Pain at night ☐ Other: _____

Have you ever had surgery? ☐ Yes ☐ No
If yes, please describe, and include dates:

	Month	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____

For men only: Have you been diagnosed with prostate disease?
☐ Yes ☐ No

For women only: Have you been diagnosed with:
☐ Pelvic inflammatory disease
☐ Endometriosis
☐ Trouble with your period
☐ Complicated pregnancies or deliveries
☐ Pregnant, or think you might be pregnant?
☐ Other gynecological or obstetrical difficulties?

CURRENT CONDITION(S) / CHIEF COMPLAINT(S):
Describe the problem(s) for which you seek physical therapy:
_____
_____
_____

	Month	Year
When did the problem(s) begin (date)?	_____	_____

What happened? _____
_____
_____

Have you ever had the problem(s) before?
☐ Yes.
What did you do for the problem(s)? _____
_____
Did the problem(s) get better? ☐ Yes ☐ No
☐ No.

How are you taking care of the problem(s) now? _____
_____
What makes the problem(s) better? _____
_____
What makes the problem(s) worse? _____
_____
What are your goals for physical therapy?_____
_____

Are you seeing anyone else for the problem(s)? (Check all that apply)
☐ Acupuncturist
☐ Cardiologist
☐ Chiropractor
☐ Dentist
☐ Family practitioner
☐ Internist
☐ Massage therapist
☐ Neurologist
☐ Obstetrician/gynecologist
☐ Occupational therapist
☐ Orthopedist
☐ Osteopath
☐ Pediatrician
☐ Podiatrist
☐ Primary care physician
☐ Rheumatologist
☐ Other: _____
_____

How has the injury affected you emotionally?
☐ Depression ☐ Withdrawal
☐ Anger ☐ Anxiety
☐ None ☐ Other _____

What is the severity of your emotional reaction?
Scale of 1(low) – 10 (high) _____

FUNCTIONAL STATUS / ACTIVITY LEVEL:
(Check all that apply)
☐ Difficulty with locomotion / movement:
- ☐ Bed mobility
- ☐ Transfers (such as moving from bed to chair, from bed to commode)
- ☐ Gait (walking)
  - ☐ On level ☐ On ramps
  - ☐ On stairs ☐ On uneven terrain

☐ Difficulty with self-care (such as bathing, dressing, eating, toileting)
☐ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)
☐ Difficulty with community and work activities/integration
- ☐ Work / school
- ☐ Recreation or play activity

MEDICATIONS:
Do you take any prescription medications? ☐ Yes ☐ No
If yes, please list: _____
_____
_____

Do you take any non-prescription medications? (Check all that apply)
☐ Advil/Aleve
☐ Antacids
☐ Ibuprofen/Naproxen
☐ Antihistamines
☐ Aspirin
☐ Decongestants
☐ Herbal supplements
☐ Tylenol
☐ Other: _____
_____

Have you taken any medications previously for the condition for which you are seeing the physical therapist? ☐ Yes ☐ No
If yes, please list: _____
_____

OTHER CLINICAL TESTS: (Please list)

	Month	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ANY COMMUNICATION DIFFICULTIES:
(Check all that apply)
☐ Speech ☐ Hearing
☐ Short term memory ☐ Long term memory

I have reviewed the above information and agree with all statements.

CLIENT:_____ **DATE:** _____
Reviewed with patient:
THERAPIST:_____ **DATE:** _____

Pelvic Floor Functional Questionnaire

The following questions may take some time to complete and are personal, however their completion before your evaluation will allow us to be very focused in our assessment and decrease the cost of your treatment.
Please indicate which of the following answers best complete the question for your symptoms. If leakage of stool or urine is not one of your symptoms, skip to question #**8** and proceed. Thank you.

Patient Name _____ **Date** _____

1. Leakage of:
- No Leakage □
- Urine □
- Stool □
- Urine & Stool □

2. Frequency of leakage:

	Urine	Stool
Never	□	□
Less than **1**x/month	□	□
More than **1**x/month	□	□
Less than **1**x/week	□	□
More than **1**x/week	□	□
Almost every day	□	□
More than **1**x/day	□	

3. Number of pads used/day: □

4. Type of pads used:
- None worn □
- Panty shields □
- Mini pads □
- Maxi pads □
- Serenity/Poise □

5. Severity/Incident:

Urine		Stool	
Few drops	□	Smear/stain	□
Wet underwear	□	Small amt.	□
Wet outerwear	□	Med/lg amt	□

6. Position/activity which causes leakage:
- Any position/no activity required □
- Lying to sitting to standing □
- Strong urge □
- Coughing, laughing, sneezing □

7. Able to delay the need to urinate or have bowel movement:

	Urine	Stool
Indefinitely	□	□
More than **1** hour	□	□
1/2 hour	□	□
15 minutes	□	□
1 - 2 minutes	□	□
Not at all	□	□

8. Fluid intake per day (**8** oz. glasses):
- **9**+ drinks/day □
- **6 - 8** □
- **3 - 5** □
- **1 - 2** □

Number of caffeinated drinks/day _____

9. Pain location:
- Rectal □
- Vaginal □
- Abdominal □
- Low back □
- Gluteal □

10. Frequency of pain:
- Never □
- More than **1**x/month □
- More than **1**x/week □
- Less than **1**x/week □
- Almost every day □
- More than **1**x/day □
- Constant □

11. Intensity of pain: **0 = no pain, 10 = severe pain**
- **0** □
- **1-2** □
- **3-5** □
- **6-8** □
- **9-10** □

12. Prolapse (feeling of pressure or falling out):
- Never □
- **1**x/month with period □
- Pressure at end of day □
- Pressure with straining □
- Pressure with standing □
- Pressure all day □

13. Frequency of urination:

Day:	every **5** or more hours	□
	every **3 – 4** hours	□
	every **2 ½** hours	□
	every **2** hours	□
	every **1½** hours	□

****

Night:	**0** x/night	□
	1x/night	□
	2x/night	□
	3x/night	□
	4x/night	□

14. Difficulty starting urination or having bowel movement:

	Urine	Stool
Never	□	□
More than **1**x/month	□	□
More than **1**x/week	□	□
Almost every day	□	□

15. Frequency of bowel movements:

- **2**x/day □
- **1**x/day □
- Every other day □
- Once every **4 - 7** days □
- Other □

16. Ability to stop flow of urine:

- Can stop immediately □
- Can maintain a deflection in stream □
- Can partially deflect stream □
- Unable to deflect slow stream □

17. How I feel about this problem:

- No problem □
- Minor inconvenience □
- Slight problem □
- Moderate problem □
- Major problem □

18. Confidence in my ability to control this problem:

- Complete confidence □
- Moderate confidence □
- Little confidence □
- No confidence □

What do you consider your main problem? _____

_____

_

Briefly describe how this problem has affected your life _____

_____

_

Date of last pelvic exam _____ Date of last urinalysis _____

Are you sexually active? □ Yes □ No

History of / or present sexually transmitted diseases? □ Yes □ No

If yes, what type? _____

Pain or problems with intercourse, urination, bowel movements (please explain): _____

_____

_

Have you ever been taught how to do pelvic floor or Kegel exercises? □ Yes □ No

If yes, by whom? _____

How often do you perform pelvic floor exercises? _____

Do you have any metal/plastic implants? □ Yes □ No

Do you have any comments or concerns not addressed in this questionnaire? _____

_____

_

_____ _____

Patient Signature **Date**

Acct#_____
Patient_____
Medical Record #_____

Financial Responsibility/Assignment
The Women's Hospital
Newburgh, IN 47630

AGREEMENT TO PAY SERVICES RENDERED

The Patient is responsible for paying the amount of all charges for medical services and products ("medical charges") in accordance with the regular rates. We accept cash, check, Visa, MasterCard, American Express and Discover. Patients or responsible parties should be proactive in arranging for payment of all medical charges. Please contact our Financial Counseling Services at 812-842-4240 if you have questions or need assistance.

In consideration of The Women's Hospital and all associated providers rendering medical services and products for the above named Patient, the undersigned agree to be jointly and severally responsible with the Patient for all medical charges. In the event the Patient is not insured, or insurance does not cover all medical charges, we agree to pay the uninsured portion of the medical charges, which amount is entirely due and payable at the time of the Patient's discharge. Any credit will be applied to outstanding balances prior to being refunded. I/we understand that past due patient accounts that are not subject to financial agreements with The Women's Hospital and associated providers will be submitted to a collection agency. I/we agree that I/we will pay all attorney fees and court costs incurred by The Women's Hospital and associated providers, in the collection of all sums due The Women's Hospital and associated providers. If I/we provide The Women's Hospital or associated providers with our cell phone number, I/we authorize The Women's Hospital or associated providers to call our cell phone either manually or by auto-dialer in order to collect any amounts I/we owe. I understand that any email I provide is my personal email and I authorize The Women's Hospital or associated providers to contact me via that email address.

WORKER'S COMP/LIABILITY/AUTO ACCIDENT

If the reason for my visit is related to a workers comp claim, liability claim, or auto accident, I understand that I am responsible for providing The Women's Hospital and associated providers with complete billing information, including police report, claim number, etc. as appropriate, within seven (7) business days. I understand that if I do not provide this information or these claims are denied, the balances then become the patient's responsibility.

PHYSICIAN FINANCIAL INTEREST DISCLOSURE

Deaconess Women's Hospital of Southern Indiana is a limited liability company organized under the laws of the State of Indiana. The hospital is privately owned, and a portion of our ownership includes a group of physicians. If you would like to receive a list of the physicians who are hospital owners, please ask your admitting representative. This disclosure is provided in accordance with Centers for Medicare and Medicaid Services.

ASSIGNMENT OF INSURANCE AND/OR EMPLOYEE PLAN BENEFITS TO HOSPITAL AND DOCTORS

In consideration of services rendered from time to time by The Women's Hospital and associated providers, all attending and consulting physicians and any ancillary services or other similar services rendered to me or to a member of my family, I hereby assign all insurance and/or employee plan benefits which I have or to which I may have a right. This assignment is a relinquishment and assignment of all legal or equitable interest which I have in any insurance and/or employee plan benefits which exist by reason or contract or otherwise, including, but not limited to Major Medical and other special coverages; this assignment includes the right to pursue any and all claims procedures or other administrative remedies available to me under any insurance policy or employee benefit plan or under any state or federal law, including the right to appeal any adverse benefit determinations thereunder; this assignment includes the right to bring a civil action in state or federal court to recover benefits due me under the terms of any insurance policy or employee benefit plan; this assignment may not completely discharge my full indebtedness to The Women's Hospital and all associated providers; this assignment is irrevocable except upon full payment of all indebtedness, or by express written agreement between The Women's Hospital and associated providers , and the undersigned; this assignment does not constitute payment for indebtedness and does not relieve the undersigned from liability for unpaid indebtedness. In the event that insurance and/or employee plan benefits to which I am entitled are paid directly to me for indebtedness incurred by me or a member of my family, or a person for whom I am financially responsible, I agree that I will immediately deliver all such benefits received.

AUTHORIZATION FOR RELEASE OF INFORMATION BY HOSPITAL AND DOCTORS

The Women's Hospital and all associated providers, all attending and consulting physicians and any ancillary services or other similar services are hereby authorized to furnish such professional information, in accordance with the policy of said hospital and the physicians, as may be necessary for the completion of my claim from the medical records compiled from time to time during treatment. The Women's Hospital and all associated providers, and said physicians are hereby released from all legal liability that may arise from the release of the information requested.

I have read the above and foregoing assignment of insurance benefits, promise to pay, and authorization for release of information and fully understand the terms thereof.

_____ and/or _____
Patient Guarantor, Relative or Representative

_____ _____
Witness Date

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES

I have received a Notice of Privacy Practices from The Women's Hospital.

Date:_____ Signature:_____
(May only be signed by patient, guardian, Power of Attorney or parent of minor child)

A Notice was provided but no acknowledgement received

Notice was provided but no acknowledgement of receipt was obtained due to:

[ ] Patient refused
[ ] Patient too ill to sign
[ ] Patient unlikely to comprehend
[ ] Patient asleep/unconscious
[ ] Emergent condition

Witness:_____ Date:_____
May be signed by family or staff.

Affix patient label here or print

Patient name:_____

Patient DOB:_____