

# NEW EVALUATION HEALTH QUESTIONNAIRE



**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **DOB:** \_\_\_ / \_\_\_ / \_\_\_ **SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Home Phone #** (    ) \_\_\_\_\_ - \_\_\_\_\_ **Cell #** (    ) \_\_\_\_\_ - \_\_\_\_\_ **Work#** (    ) \_\_\_\_\_ - \_\_\_\_\_

**Street:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Email Address:** (Please print neatly) \_\_\_\_\_

**Do we have permission to contact you by email?** Yes \_\_\_\_\_ No \_\_\_\_\_ Your email is for internal use only and will not be sold to third parties.

**Occupation:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**Emergency Contact's PH#** (    ) \_\_\_\_\_ - \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Insurance Cardholder's Name:** \_\_\_\_\_ **DOB:** \_\_\_ / \_\_\_ / \_\_\_

**Have you ever had or been told you had any of the following:** (Check if yes)

- |   |   |
|---|---|
| <input type="checkbox"/> Cardiovascular Disease                       | <input type="checkbox"/> Gastrointestinal Disease |
| <input type="checkbox"/> High Blood Pressure                          | <input type="checkbox"/> Neurological Disorder    |
| <input type="checkbox"/> Respiratory Disease                          | <input type="checkbox"/> Rheumatoid arthritis     |
| <input type="checkbox"/> Cancer                                       | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Pelvic Floor Dysfunction (incontinence/pain) | <input type="checkbox"/> Osteoarthritis           |
| <input type="checkbox"/> Unexplained weight loss                      | <input type="checkbox"/> Allergies                |
| <input type="checkbox"/> Diabetes: Type I or Type II                  | <input type="checkbox"/> Kidney Disease           |
| <input type="checkbox"/> Other: _____                                 |   |

**Explain if yes:**

\_\_\_\_\_  
\_\_\_\_\_

**List all hospitalizations:** Operations, serious illness, injuries, etc.

\_\_\_\_\_  
\_\_\_\_\_

**Your present weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_

**Are you pregnant?** \_\_\_\_\_ **Do you currently have any illnesses?** \_\_\_\_\_

**Please describe your activity level prior to this injury/condition:**

\_\_\_\_\_  
\_\_\_\_\_

List all your current medications: Prescription, over the counter, vitamins & herbal.

**NAME**

**DOSE**

**FREQUENCY**

---

---

---

---

---

---

---

---

**What is your reason for seeking therapy at this present time?**

---

---

**What type of diagnostic testing have you had for this condition?** Examples: x-rays, MRI, etc

---

---

---

**Have you ever had therapy in the past for this injury/condition? If so, when?**

---

---


**Please rate your level of pain on a 0-10 scale.**

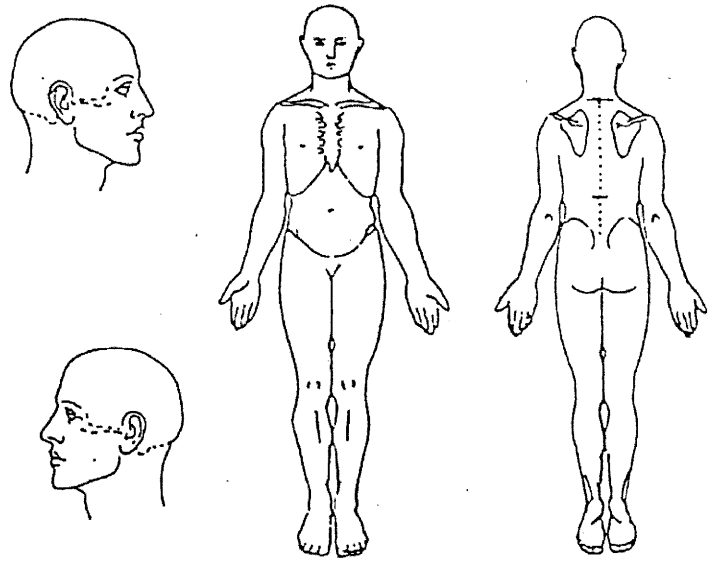
**Rate your pain:**

At worst: \_\_\_\_\_

At best: \_\_\_\_\_

Current: \_\_\_\_\_

**Mark areas of pain on body diagram.** 



I certify that the above information is true and accurate to the best of my knowledge.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# PELVIC FLOOR QUESTIONNAIRE

**Number of Pregnancies:** \_\_\_\_\_ **Delivery:** Vaginal: \_\_\_\_\_ Cesarean: \_\_\_\_\_

**Problems with delivery?** \_\_\_\_\_

**Have you gone through menopause?** \_\_\_\_\_ **Do you take hormone replacements?** \_\_\_\_\_

**Do you have a history of yeast infections?** \_\_\_\_\_ **Urinary tract infections?** \_\_\_\_\_

**Do you currently have an infection?** \_\_\_\_\_

**Are you sexually active?** \_\_\_\_\_ **Is there pain associated?** \_\_\_\_\_

**Do you feel that you urinate too frequently?** \_\_\_\_\_ **How often?** \_\_\_\_\_

**How long can you hold back the urge to urinate?** \_\_\_\_\_

**Do you ever feel a sudden urge to urinate?** \_\_\_\_\_

**Do you have to get up to urinate at night?** \_\_\_\_\_ **How often?** \_\_\_\_\_

**Is the volume of urine you pass:**  small  normal or  large

**Do you have difficulty holding your urine when:** (check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Lifting             | <input type="checkbox"/> In the cold             |
| <input type="checkbox"/> Bending             | <input type="checkbox"/> Running water           |
| <input type="checkbox"/> Walking to bathroom | <input type="checkbox"/> Sneeze, laugh, or cough |

**Do you have to strain to empty your bladder/bowel?** \_\_\_\_\_

**Do you experience uncontrollable loss of stool or stool seepage?** \_\_\_\_\_

If so, is the amount you lose:  stain/smear  small  medium  large

**How often do you have a bowel movement?** \_\_\_\_\_

**Typical stool consistency:** Choose the most frequent option.

- Hard lumps or pellet like  Firm but formed  Soft but formed  Loose

**Do you restrict your fluid intake?** \_\_\_\_\_

If so, why? \_\_\_\_\_

**Do you experience pelvic pain?** \_\_\_\_\_

**Have you experienced any of the following?**

- Domestic violence  Rape  Sexual abuse/molestation

**Symptom Severity Scale:**

**Rate the following statement as it applies to you today:** 0 being not true at all, 10 being true all the time.

My problem is controlling my life:

0    1    2    3    4    5    6    7    8    9    10

### UROGENITAL DISTRESS INVENTORY SHORT FORM (UDI-6)

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas, but please fill out this form as completely as possible.

| Do you experience, and if so, how much are you bothered by... | Not at all | Slightly | Moderately | Greatly |
|---|------------|----------|------------|---------|
| Frequent urination  | 0          | 1        | 2          | 3       |
| Leakage related to feeling of urgency                         | 0          | 1        | 2          | 3       |
| Leakage related to physical activity, coughing, or sneezing   | 0          | 1        | 2          | 3       |
| Small amounts of leakage (drops)                              | 0          | 1        | 2          | 3       |
| Difficulty emptying bladder                                   | 0          | 1        | 2          | 3       |
| Pain or discomfort in lower abdominal or genital area         | 0          | 1        | 2          | 3       |

### INCONTINENCE IMPACT QUESTIONNAIRE-SHORT FORM (IIQ-7)

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage.

| Has urine leakage affected your...                                   | Not at all | Slightly | Moderately | Greatly |
|--|------------|----------|------------|---------|
| 1. Ability to do household chores (cooking, housecleaning, laundry)? | 0          | 1        | 2          | 3       |
| 2. Physical recreation such as walking, swimming, or other exercise? | 0          | 1        | 2          | 3       |
| 3. Entertainment activities (movies, concerts, etc.)?                | 0          | 1        | 2          | 3       |
| 4. Ability to travel by car or bus more than 30 minutes from home?   | 0          | 1        | 2          | 3       |
| 5. Participation in social activities outside your home?             | 0          | 1        | 2          | 3       |
| 6. Emotional health (nervousness, depression, etc.)?                 | 0          | 1        | 2          | 3       |
| 7. Feeling frustrated?   | 0          | 1        | 2          | 3       |

Items 1 and 2 = physical activity; Items 3 and 4 = travel  
Item 5 = social/relationships; Items 6 and 7 = emotional health

**Scoring:** Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

**Reference:** Uebersax, J.S., Wyman, J.F., Shumaker, S.A., McClish, D.K., Fantl, J.A., & the Continence Program for Women Research Group. (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: the Incontinence Impact Questionnaire and the Urogenital Distress Inventory. *Neurology and Urodynamics*, 14(2), 131-139.



**141 HAMPTON CIRCLE  
ROCHESTER HILLS, MI 48307  
(248) 853-7555**

## **BLUE CROSS BLUE SHIELD**

We **accept** assignment from Blue Cross, but the insurance checks **may be made out to you and sent to you**. When you receive these checks in the mail, please bring them in along with the Explanation of Benefits (we will make a copy of the paperwork and return the original to you). You should receive the first check approximately 3-4 weeks after your first visit and then one a week until your final visit has been paid. After you have been discharged, please mail us the remaining checks along with a copy of the Explanation of Benefits.

Please sign at the bottom of this page to insure that you have been informed of this policy. Thank you for your cooperation in this very important matter.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



**141 HAMPTON CIRCLE  
ROCHESTER HILLS, MI 48307  
(248) 853-7555**

## **NOTICE OF PRIVACY PRACTICES AND CONSENT FORM**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. Before we begin any healthcare treatment we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this physical therapy office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this physical therapy office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. We may use or disclose your health information to your attending and referring physician.
3. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
4. Patients have the right to receive a copy of their health record in electronic format if records are stored in electronic format. The request will be processed within 30 days with a one times 30 day extension if required.
5. A patient's written consent need only be obtained one time for all subsequent care given in this office.
6. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for any care given prior to the request to revoke consent, but would apply for any treatment given after the request has been received.

7. As stated in #3 we must disclose your health information to you. We may also disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.
8. Patients 18 years and older will be considered as an adult and will be responsible for making their own decisions.
9. We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages or letters.
10. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
11. The patient has the right to request that information not be sent to their health plan when the patient is paying out of pocket in full for the service(s) performed.
12. Patients have the right to file a formal complaint with our privacy official about any possible violation of these policies and procedures.
13. If the patient refused to sign this consent for the purpose of treatment, payment and healthcare operations, the physical therapist has the right to refuse treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



**141 HAMPTON CIRCLE  
ROCHESTER HILLS, MI 48307  
(248) 853-7555**

**To Our Patients Regarding**

## **Cancellations and No-Shows**

- The following are our policies regarding cancellations and no-shows. We take this subject very seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you to achieve your goals in treatment.
- We require 24 hours' notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- There is a \$25.00 charge for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally.
- For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.



- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for wind-surfing. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are hurt; You, because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist, who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**INTERVIEWER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



**141 HAMPTON CIRCLE  
ROCHESTER HILLS, MI 48307  
(248) 853-7555**

## **PAYMENT PROVISIONS AUTHORIZATION**

The term "healthcare benefits" in the following paragraphs means Medicare, Medicaid, maternal and infant health benefits, BCBS, commercial health insurance benefits, health maintenance organization, preferred provider organization, or managed care plan coverage, as applicable.

I request payment on my/the patient's behalf of all health care-benefits for services provided by Neil King PT.

I assign and transfer to Neil King PT all health care benefits applicable to my/the patient's care. I authorize and direct that all such health care benefits be paid directly to Neil King PT.

I understand that my insurance benefits were verified with my insurance company at the beginning of my treatment, and the deductible amount may change based on what was verified. I am also aware that during my treatment my deductible may reset and my account will be adjusted accordingly, and I will be responsible for any and all charges that may occur.

I understand that while I am being treated by Neil King Physical Therapy, it is my responsibility to notify them of any changes in my insurance coverage. Any additional charges (deductible, co-pay, etc.) will be the patient's responsibility. If a new insurance requires pre-authorization & patient doesn't notify us, then the patient will be responsible for all the therapy sessions rejected by the insurance company.

I agree personally to pay for any physical therapy charges not covered by or collected from any applicable health care benefit program, including any deductibles and coinsurance amounts.

I certify that I have read this for and that I understand it and consent to it. If the signer is not the patient, the signer certifies that he is the patient's duly authorized representative.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



**141 HAMPTON CIRCLE  
ROCHESTER HILLS, MI 48307  
(248) 853-7555**

## **ATTENTION MEDICARE** **PATIENTS**

If you are receiving **HOME HEALTHCARE** for any reason you must notify our office at the time of your evaluation.

If for any reason you fail to notify us charges for Physical Therapy are not covered then you will be held responsible for payment.

I certify that I have read this form and that I understand it and consent to it. If the signer is not the patient, then the signer certifies that he is the patient's duly authorized representative.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_