# PHYSICAL THERAPY FOR WOMEN

**Business Office**
**Phone:** **817-247-1130**
**Fax:** **817-292-7930**

**Treatment Locations:**
**Fort Worth**
**Dallas**
**Colleyville**

Dear Valued Patient:

Welcome to Physical Therapy for Women. It is my goal to provide you with therapy that will help you reach your maximum potential. Cooperative effort is the key to success in your therapy treatment. Cooperation not only with you, but also with your physician, other health care providers, and your family is important in obtaining your goals.

At Physical Therapy for Women, **I look at the person as a whole**, not just the body region that is impaired. I am privileged to work with other health care providers as an interdisciplinary team, taking into account the whole person. Each treatment session includes direct treatment, consultation, home programming, and documentation of the services. Direct treatment addresses the goals and objectives established in your treatment plan. Consultation includes updating current issues and concerns. Home programming involves patients and family members in the overall success of treatment. Documentation at the time of service assures accurate documentation of the events of the session. You may expect the direct therapy portion of your session to end approximately 5 minutes before the scheduled end of your session to allow time to document the events and to clarify your questions.

One of my goals is to begin and end sessions in a timely manner. I recognize that your time is valuable. Therefore, if there is ever a time when you have not been escorted into treatment within 10 minutes following your scheduled appointment, please inform the receptionist. In order for your treatment plan to be effective, you must adhere to the appointments as they have been recommended and scheduled. Should an occasion arise that you will be unable to keep your scheduled appointment, I ask that you call in advance to reschedule your appointment. You may lose your regularly scheduled treatment time or be discharged from therapy if you miss 3 appointments without notifying the office in advance and/or you may be charged for those missed sessions. This is a courtesy to all of the patients and staff, so that we are optimizing our appointments to everyone's benefit.

I welcome you to Physical Therapy for Women, and trust that you will achieve your maximum potential of rehabilitation. I look forward to serving you, while reaching and improving upon my standards of excellence.

Sincerely yours,

Physical Therapy for Women

***Please note that we are a perfume/cologne-free environment, due to sensitivities of customers and staff.***

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## PATIENT INFORMATION

Patient's Name _____ DOB_____ Age_____

Street _____

City _____ State _____ Zip Code_____

Phone #'s:(H)_____(Cell)_____ (W) _____

Occupation _____

Employer _____ E-mail_____

Do you Text? ☐ Yes ☐ No

**********

Spouse Information

Name: _____ Emergency Contact: _____

Telephone _____ Alternate Phone: _____

Employer:_____ Occupation: _____

**********

Who may we thank for your referral? _____ Physician_____

Diagnoses_____

_____

I understand that **I am responsible for my bill**.

Signature_____ Today's Date:_____

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## CONDITIONS AND CONSENT FOR OUTPATIENT EVALUATION AND TREATMENT

I. COOPERATION WITH EVALUATION AND TREATMENT:

A. I understand that in order for therapy to be effective, I must come as recommended and scheduled unless there are unusual circumstances that prevent me from attending therapy.

B. I understand that I may be discharged from therapy if I fail to keep three (3) appointments without calling to cancel.

C. I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss this with my therapist.

II. NO WARRANTY:

Physical Therapy for Women does not promise a cure for my condition. They will share with me the available statistics and studies regarding results of therapy treatment for my condition. They will discuss treatment options with me.

III. INFORMED CONSENT TO EVALUATE AND TREAT

The term "informed consent" means that the potential risks, benefits and alternatives of the therapy evaluation and treatment have been explained to you. The facility provides a wide scope of services and you will receive information at the initial treatment session on the treatment options available for your condition.

1. **Potential Risks:** If your evaluation or treatment is for musculoskeletal or neurological dysfunction, you may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is typically temporary and will probably subside in 24 hours.
2. **Potential Benefits:** These include an improvement in your symptoms and/or an increase in your ability to perform your daily activities. You will have greater knowledge on managing your condition and the resources available to you. If your treatment sessions are for musculoskeletal or neurological dysfunction, you may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain.
3. **Alternatives:** If you do not wish to participate in the recommended evaluation or treatment program, you may discuss this with your therapist.
4. **Treatment may consist of:** CranioSacral Therapy, Visceral Mobilization, Myofascial Release, Strain/Counter Strain, Deep Tissue Mobilization, Muscle Energy Techniques, Lymph Drainage, and various other massage therapy techniques.
5. **Body Parts to be treated:** Any part of the body may have fascial restrictions. Genitalia may be treated. Lymph Drainage of the breast may be beneficial for breast health, if indicated. Appropriate draping will always be utilized. If you are uncomfortable for any reason, you may request your treatment to be terminated at any time, and the session will end.

Based on the information I have received from the therapist, I voluntarily consent to a therapy evaluation and/or treatment. I understand that I may withdraw at any time.

| PATIENT'S SIGNATURE | PATIENT'S PRINTED NAME | DOB | DATE |
|---|---|---|---|

| THERAPIST'S SIGNATURE | THERAPIST'S PRINTED NAME | DATE |
|---|---|---|

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# FINANCIAL INFORMATION FOR PATIENTS

**CHARGES AND PAYMENTS**: Physical Therapy for Women's fee schedule and payment options can be discussed prior to the rendering of services. Payments are due when services are rendered. To keep your costs lower, only checks or cash are accepted for payment. Physical Therapy for Women will charge a return check fee of **$30.00** per returned check. Returned check fee must be paid in cash.

**CANCELLATION**: Your appointment time is scheduled specifically for you, therefore Physical Therapy for Women requires prior notification of cancellation of all therapy sessions. Failure to cancel an appointment may result in billing for the full regular fee. Third party reimbursement **does not** pay for unattended sessions, therefore "no show" charges will not be reimbursed by your insurance.

**Payment in full is required at the time services are rendered.**

_____ _____
**Patient/Guarantor Signature** **Printed Name**

_____ _____
**Date of Birth** **Date**

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## MEDICAL HISTORY FOR THERAPY EVALUATION

Patient: _____ DOB:_____ Today's Date: _____

Occupation:_____Currently working? □ Yes □ No #Hrs/day____ # Days/wk _____
Physical requirements for work:_____
Current physical restrictions for work: _____
Native Language:_____ Language spoken most often:_____

## CURRENT INJURY/PROBLEM

Date of injury/problem:_____ Work Related? □Yes □No
Chief complaint: _____
What caused your problem? _____
Previous Testing: □MRI □CAT □X-Ray □Other _____
Results of testing:_____
List any assistive or adaptive equipment/devices or supports you are currently using:_____
_____

**Related Complaints of Pain:**

| | | | Constant | Intermittent | Improving | Unchanged | Worsening |
|---|---|---|---|---|---|---|---|
| Headaches | | | □ | □ | □ | □ | □ |
| Neck | | | □ | □ | □ | □ | □ |
| Mid Back | | | □ | □ | □ | □ | □ |
| Low Back | | | □ | □ | □ | □ | □ |
| Arms | R | L | □ | □ | □ | □ | □ |
| Legs | R | L | □ | □ | □ | □ | □ |

1. Mark through the line below where you **pain is right now**

_____
**No Pain** **Extreme Pain**

2. Mark through the line below where you **pain** is when **at its worse**:

_____
**No Pain** **Extreme Pain**

3. Mark through the line below where you **pain** is when **at its best**:

_____
**No Pain** **Extreme Pain**

List all medications you are currently using (prescription and over the counter):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**What makes/When is your pain better?** (Check all that are appropriate)

| | | | |
|---|---|---|---|
| □ Bending | □ Standing | □ Walking | □ Lying Down |
| □ Stationary | □ On the move | □ Mornings | □ Evenings |
| □ Sitting | □ Stand ➜ Sit | □ Sit ➜ Stand | □ As day progresses |

**What makes/When is your pain worse?** (Check all that are appropriate)

| | | | |
|---|---|---|---|
| □ Bending | □ Standing | □ Walking | □ Lying Down |
| □ Stationary | □ On the move | □ Mornings | □ Evenings |
| □ Sitting | □ Stand ➜ Sit | □ Sit ➜ Stand | □ As day progresses |

Does the pain awake you at night? □Yes □ No If yes, how frequently? _____
Do you have pain 24 hours/day? □Yes □ No

Please give any other information you feel is important concerning your injury/problem:_____
_____
_____

## GENERAL MEDICAL HISTORY

Please check yes or no to the following questions, and check whether it is related to your injury. This will help us understand your present and past medical history. This information will maximize the safety and effectiveness of your evaluation and/or treatment and is strictly confidential.

**ALL PATIENTS:**

| | | | |
|---|---|---|---|
| Do you have indigestion or heart burn? | □ Yes | □ No | |
| Do you have any heart problems or disease? | □ Yes | □ No | |
| Do you have a pacemaker? | □ Yes | □ No | |
| Do you have a heart murmur/heart valve problem? | □ Yes | □ No | |
| Do you have frequent or easy bruising or bleeding? | □ Yes | □ No | |
| Do you have high blood pressure? | □ Yes | □ No | |
| Have you had a stroke? | □ Yes | □ No | |
| Do you have diabetes? | □ Yes | □ No | |
| Do you have scoliosis? | □ Yes | □ No | |
| Do you have swelling in your arms or legs? | □ Yes | □ No | □ Injury Related |
| Do you have any fainting, dizziness, or light-headedness? | □ Yes | □ No | □ Injury Related |
| Do you have any nausea or vomiting? | □ Yes | □ No | □ Injury Related |
| Do you have any motion sickness? | □ Yes | □ No | □ Injury Related |
| Do you have epilepsy, a history of seizures, or convulsions? | □ Yes | □ No | □ Injury Related |
| Have you had changes in memory/orientation? | □ Yes | □ No | □ Injury Related |
| Do you have ringing in your ears? | □ Yes | □ No | □ Injury Related |
| Do you have any hearing problems/impairment? | □ Yes | □ No | □ Injury Related |
| Do you have visual problems or impairment? | □ Yes | □ No | □ Injury Related |
| Do you wear contacts, dentures, or hearing aids? | □ Yes | □ No | □ Injury Related |
| Do you have any difficulty swallowing? | □ Yes | □ No | □ Injury Related |
| Do you have any lung problems, breathing difficulty/disease? | □ Yes | □ No | □ Injury Related |
| Do you have bronchitis, asthma, emphysema, or COPD? | □ Yes | □ No | □ Injury Related |
| Are you awakened frequently at night? | □ Yes | □ No | □ Injury Related |
| Have you had any changes in your sleeping pattern? | □ Yes | □ No | □ Injury Related |
| Do you have unusual or frequent headaches? | □ Yes | □ No | □ Injury Related |
| Do you have extreme fatigue or loss of energy? | □ Yes | □ No | □ Injury Related |
| Have you had any increase in thirst or hunger? | □ Yes | □ No | □ Injury Related |
| Have you had any recent weight loss or weight gain? | □ Yes | □ No | □ Injury Related |
| How much? _____ | | | |
| Have you ever had pain in your back? | □ Yes | □ No | □ Injury Related |

| | | | |
|---|---|---|---|
| Have you ever had pain in your neck? | □ Yes | □ No | □ Injury Related |
| Have you ever had pain in your pelvis? | □ Yes | □ No | □ Injury Related |
| Have you had any fractured bones or joint dislocations? | □ Yes | □ No | □ Injury Related |
| Do you have arthritis or joint problems? | □ Yes | □ No | □ Injury Related |
| Do you have Fibromyalgia? | □ Yes | □ No | □ Injury Related |
| Do you have osteoporosis? | □ Yes | □ No | □ Injury Related |
| Do you have any metal implants? | □ Yes | □ No | □ Injury Related |
| Have you had any pain with urination? | □ Yes | □ No | □ Injury Related |
| Have you had any changes in urination or leaking of urine? | □ Yes | □ No | |
| Do you leak feces? | □ Yes | □ No | |
| Do you have pain with intercourse? | □ Yes | □ No | |
| Do you have irritable bowel syndrome? | □ Yes | □ No | |
| Do you have constipation? | □ Yes | □ No | |
| Have you had any changes in your bowel/bladder habits? | □ Yes | □ No | |
| Have you had any changes in stool color or rectal bleeding? | □ Yes | □ No | |
| Do you have a history of cancer or tumors? | □ Yes | □ No | |
| Have you ever had any blood disease? | □ Yes | □ No | |
| Do you have a fever or chills? | □ Yes | □ No | |
| Do you smoke? #pack/day____ # yrs____ | □ Yes | □ No | |
| Do you have a latex allergy? | □ Yes | □ No | |
| Do you have a rubbing alcohol allergy? | □ Yes | □ No | |
| Do you have other allergies? | □ Yes | □ No | |
| Do you have any difficulty communicating? (Getting your point across?) | □ Yes | □ No | |
| Are there any activities/hobbies/selfcare/or work related duties that you are unable to perform? | □ Yes | □ No | |

**Female Patients:**

| | | |
|---|---|---|
| Are you currently Pregnant? | □ Yes | □ No |
| Do you have any pregnancy-related pain? | □ Yes | □ No |
| Do you have any problems with menstruation? | □ Yes | □ No |
| Do you have endometriosis? | □ Yes | □ No |

If you answered "yes" to any of the above questions, please describe:_____

Surgical History: Check all that apply

☐ Back/neck surgery ☐ Bladder surgery ☐ Hysterectomy (abdominal__, vaginal__)
☐ Gall bladder surgery ☐ Appendectomy ☐ Hernias
☐ C-Section ☐ Ovaries removed ☐ Bowel/rectal surgery
☐ Hemorrhoidectomy
☐ Breast surgery (specify type) _____
☐ Other_____

Was your surgery injury related? ☐ Yes ☐ No
If you answered yes to the above list, please be specific with dates and outcomes.

_____
_____
_____
_____

Prior to your injury/problem did you exercise regularly? ☐ Yes ☐ No
Where?_____
How Often? _____
What exercises? _____
Are you currently exercising regularly? ☐ Yes ☐ No
Where? _____
How Often? _____
What exercises? _____

Have you ever had any falls (bike, skate board, ski, roller skating, etc.) or car accidents, list dates or age at time of injury and severity

_____
_____

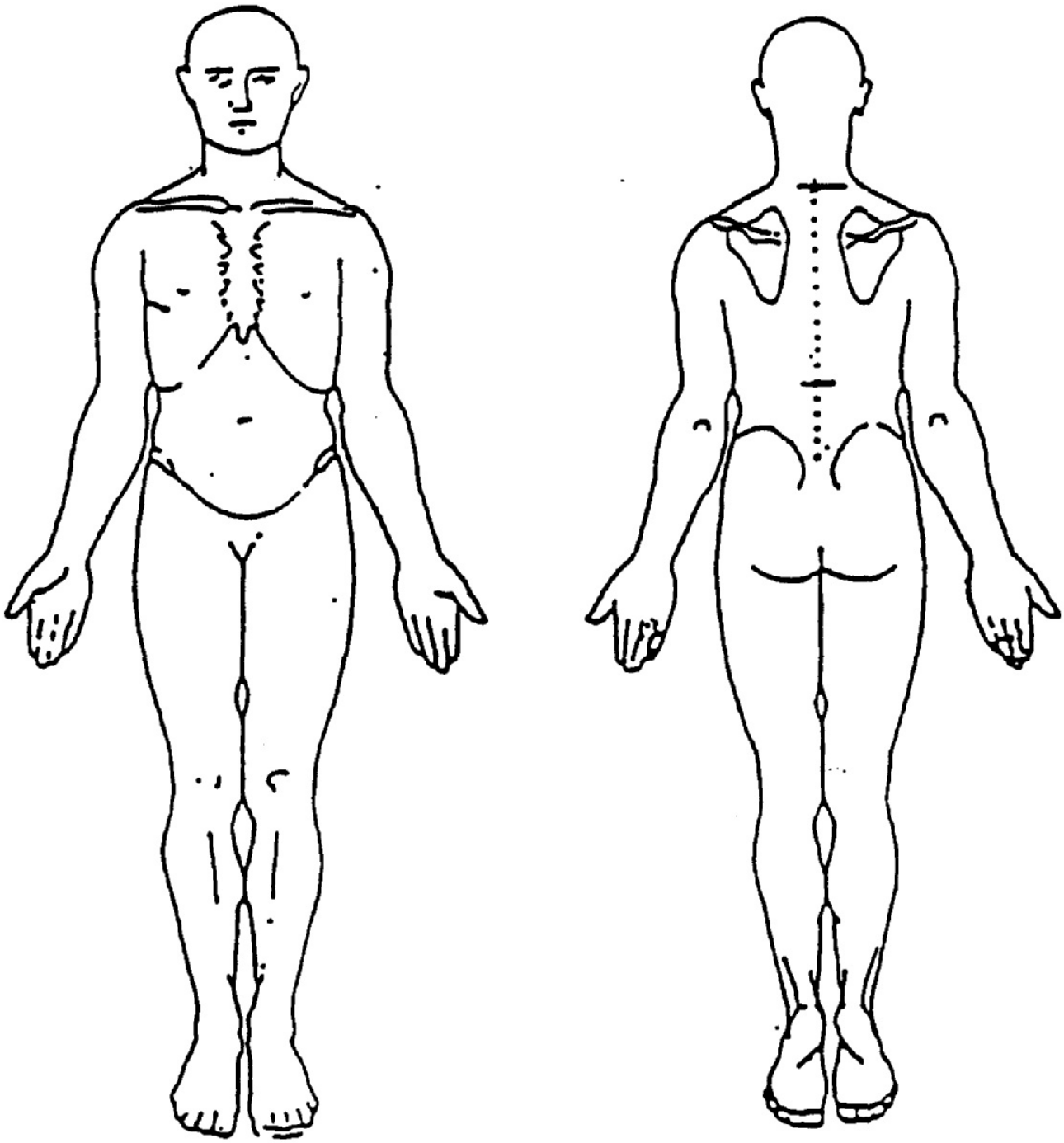
**DAILY FLUID INTAKE**: (*enter number of 8 oz cups/glasses of fluid taken daily*)

- ❑ Water ___
- ❑ Caffeinated drinks (coffee, tea, colas, chocolate) ___
- ❑ Decaffeinated drinks (coffee, tea, colas) ___
- ❑ Alcohol ___
- ❑ Juices ___
- ❑ Other ___

**BOWEL HABITS**:

How often do you have a bowel movement? _____
Do you strain having a bowel movement? ❑ Yes ❑ No
Do you experience abdominal cramping? ❑ Yes ❑ No
Do you leak/stain feces? ❑ Yes ❑ No If yes, how often?_____
Do you experience diarrhea? ❑ Yes ❑ No If yes, How often?_____
Do you use laxatives? ❑ Yes ❑ No If yes, how often/week?_____
Do you use enemas? ❑ Yes ❑ No If yes, how often/week?_____
Do you include fiber in your diet daily? ❑ Yes ❑ No If yes, how much?_____

Please draw in where you are affected by your injury/problem.



**Date:**_____

There are many words that describe pain. The following is a list of words used to describe pain. Look at each work group and place a check (✔) by the **one** word in the section which best describes your present pain. Only indicate the words that describes your pain. You do not have to choose a word in every group. If none of the words in a particular group describe your pain, go to the next word group.

1.
☐ Flickering
☐ Quivering
☐ Pulsing
☐ Throbbing
☐ Beating
☐ Pounding

2
☐ Jumping
☐ Flashing
☐ Shooting

3.
☐ Pricking
☐ Boring
☐ Drilling
☐ Stabbing

4.
☐ Sharp
☐ Cutting
☐ Lacerating

5.
☐ Pinching
☐ Pressing
☐ Gnawing
☐ Cramping
☐ Crushing

6.
☐ Tugging
☐ Pulling
☐ Wrenching

7.
☐ Hot
☐ Burning
☐ Scalding
☐ Searing

8.
☐ Tingling
☐ Itchy
☐ Smarting
☐ Stinging

9.
☐ Dull
☐ Sore
☐ Hurting
☐ Aching
☐ Heavy

10.
☐ Tender
☐ Taut
☐ Rasping
☐ Splitting

11.
☐ Tiring
☐ Exhausting

12.
☐ Sickening
☐ Suffocating

13.
☐ Fearful
☐ Frightful
☐ Terrifying

14.
☐ Punishing
☐ Grueling
☐ Cruel
☐ Vicious
☐ Killing

15.
☐ Wretched
☐ Blinding

16.
☐ Annoying
☐ Troublesome
☐ Miserable
☐ Intense
☐ Unbearable

17.
☐ Spreading
☐ Radiating
☐ Penetrating
☐ Piercing

18.
☐ Tight
☐ Numb
☐ Drawing
☐ Squeezing
☐ Tearing

19.
☐ Cool
☐ Cold
☐ Freezing

20.
☐ Nagging
☐ Nauseating
☐ Agonizing
☐ Dreadful
☐ Torturing

PRI (R) = _____ NWC = _____