ONE POINT PHYSICAL THERAPY

867 Greenwood Ave NE
Atlanta, GA 30306
404-600-4627

PATIENT INFORMATION

First Name: _____ MI: _____ Last:_____

Phone: _____ Work: _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Other Sex: ☐Male ☐Female

Social Security Number: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Would you like appointment reminders? ☐Yes ☐No If Yes; ☐Text ☐Email

How did you hear about us? ☐Doctor ☐Friend ☐Website ☐Attorney ☐Other_____

Employment Status: ☐Full time ☐Part Time ☐Other (please describe): _____

Employer: _____ Job Title: _____

PHYSICIAN INFORMATION

OBGYN/Midwife:_____ Phone:_____

Did your doctor refer you? ☐Yes ☐No

Reason for Referral:_____

Other physicians you see:_____ Specialty:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____

Home/Cell Phone:_____ Work Phone: _____

INSURANCE INFORMATION

Insurance Company Name:_____ DOB of Guarantor:_____

Insured Party: ☐Self ☐Spouse ☐Parent ☐Employer ☐Other

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Secondary Insurance information (if applicable)

Secondary Insurance Name:_____ Phone Number: _____

PATIENT HISTORY

What is the reason for your visit? _____

Have you been treated for this condition before? ☐Yes ☐No

If yes, where and when? _____

Pain

Do you have pain with:

Sexual intercourse: ☐Yes ☐No Pelvic exam: ☐Yes ☐No

Tampon use: ☐Yes ☐No Back, leg, groin, abdominal pain: ☐Yes ☐No

Please circle the level/number of pain you experience on a daily basis:

[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Possible Pain

MEDICAL HISTORY

Check all that apply:

☐Allergies	☐Anxiety	☐Osteoarthritis
☐Smoker	☐Asthma	☐Seizures
☐Heart Disease	☐High/Low Blood Pressure	☐Pacemaker
☐Heart Attack	☐Fibromyalgia	☐Headaches
☐Metal Implants	☐Osteoporosis/Osteopenia	☐Stroke
☐Autoimmune Disorder	☐Cancer	☐Diabetes
☐Circulatory Problems	☐Kidney Problems	☐Latex Allergy
☐Multiple Sclerosis	☐Parkinson's Disease	☐HIV

Obstetric History

Are you trying to get pregnant? ☐Yes ☐No

Have you ever been pregnant? ☐Yes ☐No

If yes, please list number of pregnancies/deliveries:

Number of pregnancies _____ Date of most recent delivery _____

Number of vaginal deliveries _____ Number of cesarean deliveries _____

Birth weight of largest baby _____ Number of episiotomies _____

Were forceps or a vacuum extraction used? ☐Yes ☐No

Did you have any trouble healing after delivery? ☐Yes ☐No

Please list any complications during pregnancy/giving birth:_____

Gynecologic History

Date of last pap smear _____ Have you ever had an abnormal pap smear? ☐Yes ☐No

Date of last period _____ Do you have regular menstrual cycles? ☐Yes ☐No

Do you have pain with menstruation? ☐Yes ☐No

Do you take oral contraceptives: ☐Yes ☐No

If no do you use a different type of birth control:_____

Have you reached Menopause? ☐Yes ☐No

If yes, are you taking Estrogen Therapy? ☐Yes ☐No

Have you had a hysterectomy? ☐Yes ☐No

If yes, at what age? _____ Were your ovaries removed? ☐Yes ☐No / ☐One ☐ Both

Have you had a Mammogram? ☐Yes ☐No

If yes, when was your last one? _____

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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. Your physical therapist will discuss this option and receive your consent during your initial visit before initiating this exam.

You absolutely can say no, and your physical therapist can assess and treat the pelvic floor muscles externally (from the outside) if needed. The assessment of the pelvic floor muscles may result in soreness or discomfort temporarily. If this occurs, please discuss your symptoms with your physical therapist.

By signing this form, you agree and understand that treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat as discussed. You are always free to change your mind at any time during your course of treatment, and you are encouraged to notify your physical therapist of any changes of your preferences.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment (as described above). The second person could be a friend, family member, or clinic staff member.

Please indicate your preference with your initials:

_____YES I want a second person present during the pelvic floor muscle evaluation and treatment.
_____ NO I do not want a second person during the pelvic floor muscle evaluation and treatment.

Signature:_____ Date: _____

Printed Name: _____

Physical Therapist Signature : _____Date: _____

Printed Name: _____

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