Phone: 817-483-1746
Fax: 817-483-5874

PATIENT INFORMATION

Name:	Date of Birth:	Gender: Male / Female
Address:	City:	State/Zip:
Social Security#:	Mobile Number:	Home Phone:
Email:	Single / Married / Widowed / Divorced	
Emergency Contact/Relationship:	Phone Number:	

PRIMARY INSURANCE

Insurance Name:	Primary Insured:
Relation:	Date of Birth (If not self):
Policy#:	Group Number:

SECONDARY INSURANCE

Insurance Name:	Primary Insured:
Relation:	Date of Birth (If not self):
Policy#:	Group Number:

Work Comp/Injury

WC/Auto Date of Injury:	Adjuster:
If WC, Employer Name:	Employer Address:

We can provide automated appointment reminders via e-mail for your convenience.
Please INITIAL one option below.

I consent to receive automatic appointment reminder e-mails from Therapy Excellence

_____ No

_____ Yes, at _____@_____.com

Phone: 817-483-1746
Fax: 817-483-5874

PATIENT CONSENT

CONSENT FOR TREATMENT: I voluntarily consent to medical treatment provided at this facility. 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 be 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, and educational instruction.

1. The purpose, risk, and benefits of this evaluation have been explained to me.
2. I understand that this evaluation will involve palpation, physical examination, and possible pain provocation.
3. I understand that my pain may increase at times as a result of the evaluation and treatment.
4. I understand that I can terminate the procedure at any time.
5. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
6. I have the option of having a second person present in the room during the procedure. My decision is below

   _____ choose to have someone in the room present
   _____ decline to have someone in the room present

Initial: _____ Date: _____

FINANCIAL POLICY: I do hereby consent to the release of protected health information as needed to process my medical claims. I assign all benefit payments for services provided by Therapy Excellence to this facility. I understand that I am responsible for copayments, coinsurance, deductibles and other services not covered by my medical insurance company.

Initial: _____ Date: _____

LIABILITY: I acknowledge that I have been advised to leave my personal valuables at home and do hereby agree that this facility is not responsible for loss or damage to personal items while I am attending therapy sessions.

Initial: _____ Date: _____

Phone: 817-483-1746
Fax: 817-483-5874

NOTICE OF PRIVACY: Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Therapy Excellence cannot and does not release its patients' protected health information (PHI) without the express written consent of the patient, except as otherwise authorized or required by law to disclose such information. I understand that my personal PHI will be provided to my physicians who refer me to Therapy Excellence for treatment, other physicians I designate to receive my information, the insurance company or employer making payment for services rendered, and any individuals I specifically designate with written consent. Other than those specified above and as otherwise required by law, my medical and demographic information will not be given to any persons or entities without my express written consent for any purpose. I hereby give my consent to release my PHI, including medical information, billing information, and appointments, to the persons I have designated below. I understand that, except as explained above, the individuals listed below are the only persons to whom Therapy Excellence may disclose my PHI.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

CANCELLATION POLICY

At Therapy Excellence we pride ourselves in providing quality care on each treatment session. Same day cancellations make it impossible for us to schedule in this manner. For this reason, we respectfully request that you provide us with 24 hours' notice if you will be unable to keep a scheduled appointment. We understand that life happens-family crises, illnesses, work, etc. For this reason, we will allow one cancellation or reschedule with less than 24 hours' notice without a penalty. Any subsequent same day cancellations, reschedules or no show visits will result in a $25 fee regardless of the reason for cancellation or reschedule. We do have voicemail and email if you need to reach us outside of standard operating hours. Please call (817) 483-1746 to leave a voicemail prior to 7 a.m. on the day of your appointment to avoid the cancellation fee.

Your signature indicates that you are aware of this policy and willing to comply.

Name: _____ Signature: _____ Date: _____

TEI Witness: _____

Who can we thank for your referral to our office?
Past Patient Family/Friend Doctor Insurance Company Social Media/Ad Free Screen

SCREENING QUESTIONS

1. During the last month, have you been bothered by feeling down, depressed, or hopeless?
2. During the past month, have you often been bothered by little interest or pleasure in doing things?

Signature: _____ Date: _____

Phone: 817-483-1746
Fax: 817-483-5874

Insurance Questions

Below are 7 insurance related questions. Insurance companies require us to verify that they are the responsible party. Please answer the questions below so that we may verify that there is not another primary payer. Date of injury: _____

Are you currently receiving home health services?	Yes	No
Are you currently receiving any other therapy services?	Yes	No
Do you anticipate litigation due to your injury?	Yes	No
Is this injury the result of a fall at an establishment?	Yes	No
Is this injury the result of an auto accident?	Yes	No

Medical Questions

Please list **any other major surgeries**_____

Please list any **medications** you are taking OR provide us with a list:

Do you have any of the following conditions?

Y	N	Asthma/Emphysema/Other Breathing Disorder
Y	N	Arrhythmia/Chest Pain/Cardiac Condition/Pacemaker
Y	N	Cancer
Y	N	Stroke/TIA/Traumatic Brain Injury
Y	N	Bowel or Bladder Changes
Y	N	Unexplained Weight Loss or Gain
Y	N	High Blood Pressure
Y	N	Anxiety/Depression/Emotional or Psychological Condition
Y	N	Headache/Migraine/TMJ
Y	N	Seizure Disorder
Y	N	Hepatitis/HIV
Y	N	Osteoporosis/Osteopenia
Y	N	Fracture
Y	N	Diabetes
Y	N	Balance Difficulty/Falls
Y	N	Neurological Disease/MS/Restless Leg/ALS
Y	N	Vision/Hearing/Speech Disturbance

Phone: 817-483-1746
Fax: 817-483-5874

MEDICAL HISTORY

What is your greatest limitation or **chief complaint**? _____

What medical physicians have you seen for your condition?

Family Medicine OBGYN Urologist Neurologist Neurosurgeon Chiropractor

Have you had surgery **for this condition**? Yes No

If yes, which procedure? _____Date of surgery? _____

Number of pregnancies _____ Number of vaginal deliveries _____

Number of cesarean deliveries _____ Number of episiotomies _____

Birth weight of largest baby _____ Date of last pap smear _____

Did you have any trouble healing after delivery	Y	N
Do you have a history of sexual abuse or trauma	Y	N
Are you having regular periods/menstrual cycles	Y	N
Do you have frequent urinary tract infections	Y	N
Do you have pain with sexual intercourse	Y	N
Do you have pain with pelvic exams	Y	N
Do you have pain with tampon use	Y	N
Do you have back, leg, groin, abdominal pain	Y	N

Bladder symptoms

Do you wet the bed	Y	N
Do you have burning/pain with urination	Y	N
Do you have difficult starting a stream of urine	Y	N
Do you strain to empty your bladder	Y	N
Do you feel unable to empty bladder fully	Y	N
Do you have a falling out feeling	Y	N
Do you have an urgency of urination (a strong urge)	Y	N
Urinate more than 7 times a day	Y	N

Do you lose urine when you:

Cough/sneeze/laugh Y N Lift/exercise/dance/jump Y N On the way to the bathroom Y N

Have a strong urge to urinate Y N Hear running water Y N Other _____

Phone: 817-483-1746
Fax: 817-483-5874

Bowel symptoms

Do you strain to have a bowel movement	Y	N
Do you leak/strain feces	Y	N
Do you include fiber in your diet	Y	N
Do you have diarrhea often	Y	N
Do you take laxatives/enema regularly	Y	N
Do you leak gas by accident	Y	N
Do you have pain with bowel movement	Y	N
Do you have a very strong urge to move your bowels	Y	N

How often do you move your bowels: _____ per day, week

Most common stool consistency

_____ liquid _____ soft _____ firm _____ pellets _____ other _____

If you have pain, what is your pain at BEST in the last 72 hours? (0=none, 10=worst imaginable)

0 1 2 3 4 5 6 7 8 9 10

If you have pain, what is your pain at WORST in the last 72 hours? (0=none, 10=worst imaginable)

0 1 2 3 4 5 6 7 8 9 10

What makes pain lessen? _____ What makes pain increase? _____

Y	N	Are you pregnant?
Y	N	Are you allergic to latex?
Y	N	Are you allergic to adhesive/tape/band-aids?
Y	N	Do you use tobacco?

Signature: _____ Date: _____ Therapist Initials: _____