Patient History

Name **DOB** **Age** **Date**

1. Describe the current problem that brought you here?

2. When did your problem first begin?

3. Was your first episode of the problem related to a specific incident?
   Please describe and specify date:

4. Since that time is it: ◯ staying the same ◯ getting worse ◉ getting better
   Why or how?

5. If pain is present rate pain on a 0-10 scale 10 being the worst
   10

6. Describe the nature of the pain (i.e. constant burning, intermittent ache)

7. Describe previous treatment/exercises

8. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

- ☐ Sitting greater than minutes
- ☐ Walking greater than minutes
- ☐ Standing greater than minutes
- ☐ Changing positions (ie. - sit to stand)
- ☐ Light activity (light housework)
- ☐ Vigorous activity/exercise (run/weight lift/jump)
- ☐ Sexual activity
- ☐ With cough/sneeze/straining
- ☐ With laughing/yelling
- ☐ With lifting/bending
- ☐ With cold weather
- ☐ With triggers i.e. /key in door
- ☐ With nervousness/anxiety
- ☐ No activity affects the problem

Other, please list

9. What relieves your symptoms?

10. How has your lifestyle/quality of life been altered/changed because of this problem?Social activities (exclude physical activities), specify
Diet /Fluid intake, specify
Physical activity, specify
Work, specify
Other

11. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst

Since the onset of your current symptoms have you had:

- ☐ Fever/Chills
- ☐ Unexplained weight change
- ☐ Dizziness or fainting
- ☐ Change in bowel or bladder functions
- ☐ Malaise (unexplained tirednes
- ☐ Unexplained muscle weakness
- ☐ Night pain/sweats
- ☐ Numbness / Tingling

Other /describe:

Date of Last Physical Exam Tests performed

General Health: ◯ Excellent ◯ Good ◯ Average ◯ Fair ◯ Poor

Occupation Hours/week On disability or leave? Yes

Activity Restrictions?

Activity/Exercise: None l-2days/week 3-4days/week 5+days/week

Describe

Mental Health.- Current level of stress? High Med Low Current psych therapy? Yes

Have you ever had any of the following conditions or diagnoses? Check all that apply

Cancer
Heart problems
High Blood Pressure
Ankle swelling
Anemia
Low back pain
Sacroiliac/Tailbone pain
Alcoholism/Drug problem
Childhood bladder problems
Depression
Anorexia/bulimia
Smoking history
Vision/eye problems
Hearing loss/problems

Stroke
Epilepsy/seizures
Multiple sclerosis
Head Injury
Osteoporosis
Chronic Fatigue Syndrome
Fibromyalgia
Arthritic conditions
Stress fracture
Acid Reflux /Belching
Joint Replacement
Bone Fracture
Sports Injuries
TMJ/ neck pain

Emphysema/chronic bronchitis
Asthma
Allergies-list below
Latex sensitivity
Hypothyroid/ Hyperthyroid
Headaches
Diabetes
Kidney disease
Irritable Bowel Syndrome
Hepatitis
Sexually transmitted disease
Physical or Sexual abuse
Raynaud's (cold hands and feet)
Pelvic pain

Surgical /Procedure History

Surgery for your back/spine
Surgery for your brain
Surgery for your female organs
Surgery for your bladder/prostate
Surgery for your bones/joints
Surgery for your abdominal organs

Ob/Gyn History (females only)

Childbirth vaginal deliveries #
Episiotomy #
C-Section #
Difficult childbirth #
Prolapse or organ falling out
Other /describe

Vaginal dryness
Painful periods
Menopause - when?
Painful vaginal penetration
Pelvic/genital pain

Males only

Prostate disorders
Shy bladder
Pelvic/genital pain location
Erectile dysfunction
Painful ejaculation

Other / describe

Medications - pills, injection, patch Start date Reason for taking

Over the counter -vitamins etc Start date Reason for taking

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Symptoms

Trouble initiating urine stream
Urinary intermittent/slow stream
Strain or push to empty bladder
Difficulty stopping the urine stream
Trouble emptying bladder completely
Blood in urine
Dribbling after urination
Constant urine leakage
Trouble feeling bladder urge/fullness
Recurrent bladder infections
Painful urination

Blood in stool/feces
Painful bowel movements (BM)
Trouble feeling bowel urge/fullness
Seepage/loss of BM without awareness
Trouble controlling bowel urge
Trouble holding back gas/feces
Trouble emptying bowel completely
Need to support/touch to complete BM
Staining of underwear after BM
Constipation/straining % of time
Current laxative use -type

Other/describe:

Describe typical position for emptying:

1. Frequency of urination: awake hour's times per day, sleep hours times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   minutes hours not at all
3. The usual amount of urine passed is: small medium large
4. Frequency of bowel movements: times per day, times per week, or
5. The bowel movements typically are: watery loose formed pellets other
6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
   minutes hours not at all.
7. If constipation is present describe management techniques

8. Average fluid intake (one glass is 8 oz or one cup) glasses per day.
   Of this total how many glasses are caffeinated? glasses per day.
9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
   None present
   Times per month (specify if related to activity or your menstrual period)
   With standing for minutes or hours.
   With exertion or straining
   Other

10a. Bladder leakage - number of episodes

No leakage
Times per day
Times per week
Times per month
Only with physical exertion/cough

10b. Bowel leakage - number of episodes

No leakage
Times per day
Times per week
Times per month
Only with exertion/strong urge

11a. On average, how much urine do you leak?

- ○ No leakage
- ○ Just a few drops
- ○ Wets underwear
- ○ Wets outerwear
- ◉ Wets the floor

11b. How much stool do you lose?

- ○ No leakage
- ○ Stool Staining
- ○ Small amount in underwear
- ○ Complete emptying
- ◉ Other

12. What form of protection do you wear? (Please complete only one)

- ◉ None
- ○ Minimal protection (tissue paper/paper towel/pantishields
- ○ Moderate protection (absorbent product, maxi pad)
- ○ Maximum protection (specialty product/diaper)
- ○ Other

On average, how many pad/protection changes are required in 24 hours? # of pads

TAMARACK
PHYSICAL THERAPY

Out of Network Insurance Usage

We are an out-of-network provider, meaning we do not work with any insurance companies and are not bound by their limitations. Payment is collected at the time of service, so you won't receive any unexpected medical bills from us. We accept all major credit cards, checks, cash, Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA). Your sessions will be one-on-one, allowing us to focus entirely on your needs, something that traditional insurance models often restrict. If needed, we can provide you with a "superbill" to submit to your insurance for reimbursement, but please check with your insurance company for their specific requirements for out of network benefits.

Consider the following questions:

1. Do I have out of network benefits under my plan?
2. What is my yearly deductible for out of network services?
3. What percentage of my visit will be covered using my out of network benefits?___
4. How many visits am I allowed yearly out of network?
5. Are there any other requirements with using my out of network benefits for physical therapy (pre-authorization, etc)
6. How do I submit a superbill for reimbursement?

_____

If you have any questions, please do not hesitate to give us a call: 509-306-5105

Thank you!

t: (509) 306-5105 f: (800) 589-7414 e: davida@tamarackpt.com www.tamarackpt.com
MailingAddress:1015E2nd St#2-152CleElum,WA98922PhysicalAddress:602W.2ndStCleElum, WA 98922

Patient Demographic Information

Name: _____ DOB:_____
Age: _____

Email Address:

_____

Mailing Address:

_____

_____

Preferred Phone: _____ Secondary Phone: _____

Preferred Automated Alert for Appointment Reminders:
◯ Text ◯ Phone Call ◯ Email ◯ None

Referring Doctor Name:

_____

_____

Emergency Contact Name: _____
Relationship: _____
Phone Number: _____

If you are not the Guarantor, please fill out the following information:

Name: _____
Date of Birth: _____
Address of Guarantor:_____

_____

_____

Tamarack Physical Therapy, Inc.
602 W. 2nd St
Cle Elum, WA 98922
(509) 306-5105

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name:_____

Patient Birth Date: _____

We at Tamarack Physical Therapy are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient