Physical Therapy for women
Lymphedema & Pelvic Rehab Center
Personalized, Compassionate Care

&

PEDIATRIC HEALTH INTAKE FORM

Please answer all questions as this will help us best manage your child's care

Patient History and Symptoms:

Name of parent or guardian completing form: _____

Child's name: _____ Age:_____ Height:_____ Weight:_____

When did the problem first begin?_____

Since that time is it: ____staying the same ____ getting worse ____ getting better

Doctor name and date of the child's last visit:_____ Date of last urinalysis:_____

Previous tests for condition child is coming to PT for:

1. _____
2. _____
3. _____

Medications (prescription & over the counter)	**Start Date**	**Reason**

Does your child have or had a history of the following?

- ❑ Pelvic pain
- ❑ Diabetes
- ❑ Allergies
- ❑ Surgeries
- ❑ Kidney infection, bladder infections
- ❑ Neurological Impairments (brain, nerves)
- ❑ Low back pain
- ❑ Latex sensitivity/allergy
- ❑ Asthma
- ❑ Blood in Urine
- ❑ Vesicoureteral reflex Grade_____
- ❑ Physical or sexual abuse/trauma

Please explain YES responses:

_____

_____

1630 Military Cutoff Road, Suite 110, Wilmington, North Carolina 28403 | (910)798-2318 |
email ptforwomen@yahoo.com

Physical Therapy for women
Lymphedema & Pelvic Rehab Center
Personalized, Compassionate Care

&

PEDIATRIC HEALTH INTAKE FORM

Bladder Habits:

1. How often does your child urinate during the day? _____ x per day, every _____hours.
2. How often does your child wake up to urinate after going to bed? _____ times
3. Does your child awaken wet in the morning? __ Yes __No if yes, _____ days per week.
4. Does your child have the sensation (urge) when they need to urinate? __ Yes __No
5. How long does your child delay going to the toilet once he/she needs to urinate?
   __ Not at all __ 1-2 minutes __ 3-10 minutes
   __ 11-30 minutes __ 31-60 minutes __ Hours _____
6. Does your child take time to go to the toilet and empty their bladder? __ Yes __ No
7. Does your child have difficulty initiating their stream of urine? __ Yes __ No
8. Does your child have a slow, stop/start or hesitant stream? __ Yes __ No
9. Does your child have the feeling their bladder is still full after urinating? __ Yes __ No
10. Does your child have dribbling after urination? __ Yes __ No
11. Fluid intake:
    _____of glasses per day (8 oz or 1 cup)
    _____ of caffeinated/glasses per day
    Types of drinks:
    _____
12. Does your child leak urine throughout the day? __ Yes __ No
    If yes, what activities:

_____

1630 Military Cutoff Road, Suite 110, Wilmington, North Carolina 28403 | (910)798-2318 |
email ptforwomen@yahoo.com

Physical Therapy for women
Lymphedema & Pelvic Rehab Center
Personalized, Compassionate Care

&

PEDIATRIC HEALTH INTAKE FORM

Bowel Habits:

1. How many bowel movements: _____ per day _____ per week
2. Does your child strain to go? __ Yes __ No
3. Does your child have fecal staining on his/her underwear? __Yes __ No, how often?____
4. Does your child have a history of constipation? __Yes __ No For how long? _____

Does your child wear protection? (pads, diapers, pull-ups) __ Yes __ No

Has your child stopped or been unable to do certain activities because of their condition? (For example, embarrassed to play with friends, can't go on sleepovers, feels ashamed about leakage and avoids play dates.) __ Yes or __ No

Ask your child to rate his/her feelings as to the severity of this problem from 0-10

0 ----------5----------10

1630 Military Cutoff Road, Suite 110, Wilmington, North Carolina 28403 | (910)798-2318 |
email ptforwomen@yahoo.com

PEDIATRIC HEALTH INTAKE FORM

Pediatric Parental Consent for Evaluation and Treatment

I _____, hereby give permission to *Physical Therapy for Women Lymphedema and Pelvic Rehab Center*, to provide my minor/child, _____, under my guardianship with receiving and participating in Physical therapy as deemed appropriate. I understand that I am financially responsible for the minor and that all statements contained in the consent apply equally to myself and the minor/child. I consent for my minor/child receiving and participating in physical therapy in accordance with the facility operating policies in my absence under the following conditions:

1. In the presence of another adult family member: ~ Yes ~ No

   An adult 18 or older that I designate below, will attend with my minor/child:

   Name: _____ Relationship to minor: _____

   Name: _____ Relationship to minor: _____

2. When child is under indirect supervision by designated adult family members: __ Yes __ No

Informed consent for treatment and assessment of the pelvic floor muscles : (if applicable)

I understand that to evaluate my child's condition, it may be necessary to initially and periodically have my therapist perform a pelvic floor muscle examination. This examination is performed by observing and/or palpation the external perineal region. No internal examination is done unless the minor has had a pelvic floor examination by her doctor and/or is currently sexually active and agrees to an internal examination. This evaluation will assess skin condition, reflexes, muscle tone, length, strength & endurance, and function of the pelvic floor.

I understand my child/minor's treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and educational instruction.

Chaperone Policy: At PT For Women chaperones are offered to every patient regardless of the gender or role of the patient or clinician when performing sensitive evaluations or treatments. Sensitive evaluations or treatment include but are not limited to an evaluation, palpation, placement of instruments in genitalia, or exposure of: genitalia; rectum; breast. Pediatric patients, which include any patient under the age of 18 years of age, must have a chaperone present which does not include a family member/friend at every visit that occurs in a private treatment room .This is provided by PT for Women.

Physical Therapy for women
Lymphedema & Pelvic Rehab Center
Personalized, Compassionate Care

&

PEDIATRIC HEALTH INTAKE FORM

Release of medical records: I authorize the release of my medical records to my physicians or primary care provider or insurance company.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled with my child/minor unless there are unusual circumstances that prevent me. I agree to cooperate with and carry out the home physical therapy program assigned to my child.

No Warranty: I understand that my therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding the results of the condition for my treatment.

I certify that I have read and understand all the terms of this consent and agree to continue to abide by all of the terms of this consent.

Patient Name: _____ Date:_____

_____
Patient Signature

_____
Signature of Parent or Guardian

1630 Military Cutoff Road, Suite 110, Wilmington, North Carolina 28403 | (910)798-2318 |
email ptforwomen@yahoo.com

PEDIATRIC HEALTH INTAKE FORM

Physical Therapy for women
Lymphedema & Pelvic Rehab Center
Personalized, Compassionate Care

&

Patient Name: _____ **Nickname:** _____
(First) (Middle) (Last)

Preferred Pronouns: ☐she/her/hers ☐he/him/his ☐ze/hir/hirs ☐they/them/theirs **Date of Birth:**_____

Address: _____
(Street)

_____
(City) (State) (Zip code)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____ **Primary phone:** _____

Would you like to receive appointment reminders: _____ **If yes, by text, voice or email** _____

Note that PTFW does not encrypt emails

Email address: _____ **Would you like to be added to our email list?** _____

Student Status: ☐Not a student ☐Full-time Student ☐Part-time Student

Referring Physician: _____ **Return to Dr. Date:** _____

Reason for PT evaluation: _____ **Date of first symptom:** _____

Primary Insurance Company and Policy #_____

Policy Holder's Name_____**DOB**_____

Policy Holder's relation to patient: **Parent or guardian** **Spouse** **Dependant**

Secondary Insurance Company and Policy# (if applicable) _____

Policy Holder's Name_____**DOB**_____

Policy Holder's relation to patient: **Parent or guardian** **Spouse** **Dependant**

Emergency Contact: _____ **Emergency Contact Phone:** _____

Relationship to patient: _____

HIPAA RELEASE OF MEDICAL INFORMATION AUTHORIZATION

☐ **No - I do not want to share any of my Personal Health Information with anyone who may call on my behalf. (Besides referring provider, insurance company/payor source).**

☐ **Yes - I give permission to the following people to have access to my PHI to include appointment info, PT care related information, and billing details.**

Name_____ **Name:** _____

Name_____ **Name:** _____

This permission remains in effect unless given additional request in writing to Physical Therapy for Women, Inc.

Parent/Guardian Signature: _____ **Date:** _____

1630 Military Cutoff Road, Suite 110, Wilmington, North Carolina 28403 | (910)798-2318 |
email ptforwomen@yahoo.com

PEDIATRIC HEALTH INTAKE FORM

IMPORTANT: If you are currently receiving home health care, physical therapy, or chiropractic care, or have received physical therapy for any diagnosis this year, please let us know. This may affect your insurance coverage.

Please check and sign below:

☐ **Required: CONSENT TO TREAT:** I do hereby agree and give my consent for Physical Therapy For Women to furnish medical care & treatment that is considered necessary and proper in diagnosing or treating my physical condition.

☐ **Required: <u>Chaperone Policy</u>:** At PT For Women chaperones are offered to every patient regardless of the gender or role of the patient or clinician when performing sensitive evaluations or treatments. Sensitive evaluations or treatment include but are not limited to an evaluation, palpation, placement of instruments in genitalia, or exposure of: genitalia; rectum; breast. Pediatric patients, which include any patient under the age of 18 years of age, must have a chaperone present which does not include a family member/friend at every visit that occurs in a private treatment room .This is provided by PT for Women.

☐ **Required:** I have read and understand the financial policy given to me by ***Physical Therapy for Women, Inc.***

☐ **Required:** I have read and understand the HIPAA Form.

☐ **MEDICARE PATIENTS** - Have you received physical therapy this year? If YES – How many visits did you attend? _____

☐ I authorize Physical Therapy for Women, Inc. to use my photographic image in marketing materials advertising our services that will be viewed by the general public. This includes PTFW's website, FaceBook page, and printed marketing materials.

☐ I have completed the Credit Card Authorization form and I authorize *Physical Therapy for Women, Inc* to charge my credit card for agreed upon copayments/coinsurances. I understand that my information will be saved to file for future transactions on my account. I can cancel authorization at anytime by contacting the *Physical Therapy for Women, Inc* billing department.

_____ _____

Parent/Guardian signature **Date**

1630 Military Cutoff Road, Suite 110, Wilmington, North Carolina 28403 | (910)798-2318 |
email ptforwomen@yahoo.com