Welcome to Noonan Physical Therapy!

Thank you for choosing our clinic.
We know you have a choice of where you go.

How did you hear about our office? _____

Payment Authorization:
Verification of benefits is not a guarantee of payment. It is your responsibility to know your insurance benefits and/or limitations for therapy. Inform us immediately if your insurance coverage changes. Unless 100% of charges are reimbursed, you are responsible for the *deductible and/or coinsurance not covered by your insurance(s), which is due 30 days from receipt of your statement*.

Your co-pay is: $_____ per visit **Self-Pay:** $_____

We will collect: $_____ per visit. *This amount may not be the final amount due. You will be responsible for the remaining balance after the claim(s) is processed by your insurance(s).*

Medicare covers 80% of the allowable charges; up to an annual limit of $2010.00. Your secondary insurance may cover the remaining balance, if not, it is your responsibility. If you do not have a secondary insurance, the remaining 20% is your responsibility, and you will be billed for the amount due.
In the event that it is necessary to place the account with a collection agency, an additional 40% of the principle balance due will be added. In addition, should legal action become necessary you will be responsible for attorney's fees, interest and court costs. If your account is placed with an agency for collection or an attorney for legal action a credit report will be pulled for the sole purpose of collecting the delinquent account. If there is a bounced check, there will be a $35 fee assessed to the amount of the check. If your insurance company reimburses payment directly to you, we request you promptly sign over said check to Noonan Physical Therapy & Associates and send it along with the explanation of benefits to NPTA.

Your therapist may suggest purchasing supplies for home exercises. Be advised that the supplies may not be covered by your insurance.

Automated Appointment Reminders:

Choose One:	☐ NPTA may send email messages. _____ ☐ NPTA may send text messages. *Be aware standard text message rates may apply* Please ***Circle*** Mobile Phone Carrier: AT&T, Verizon, T-Mobile, Sprint, Other: (specify)_____ ☐ NPTA may call me for reminders. ☐ I decline appointment reminders.

Cancellation, No Show and Late Arrivals Policy

We reserve the right to charge a $40 fee for appointments cancelled or not attended without 24 hours advance notice. Additionally, if you are greater than 15 minutes late for your appointment this will be considered a cancellation. To cancel appointments, please call the office where you made your appointment. You may leave a detailed message on our voicemail and we will return your call to confirm your cancellation and your next appointment.

By signing below I confirm that I understand that it is my responsibility to know what my insurance benefits are as well as the cancellation policy. I hereby authorize NPTA to furnish my doctor(s), my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness/injury.

_____
Patient's Name / In Case of a Minor, Guardian's Name

_____ _____
Signature **Date**

PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Injury: _____ Date of Surgery: _____

I. Please check if you have or have had any of the following cancers.
☐Prostate ☐Breast Cancer ☐Kidney ☐Thyroid ☐Lung ☐Skin Other _____

II. Please check if you have or have had any of the following conditions.
☐Heart problems (Angina, heart Attack, Valve)
☐Pace Maker
☐Deep venous thrombosis (blood clots in the legs)
☐High blood pressure
☐Stroke
☐Asthma
☐Hernia/Hernia Repair
☐Chemical dependency (eg., alcoholism)
☐Depression
☐Hypothyroid (low) / Hyperthyroid (high)
☐Diabetes: Before / After age 18
☐Multiple sclerosis
☐Rheumatoid arthritis
☐Degenerative osteoarthritis
☐Gout
☐Ankylosing spondylitis
☐Hepatitis
☐Stomach/duodenal ulcers
☐Epilepsy/seizures
☐Headaches (more than 1 per week)
☐Urinary incontinence
☐Osteoporosis
☐Currently Pregnant
☐Other illnesses diagnosed by a physician
Please list: _____

III. Please check if you have had any of the following surgeries.
☐Caesarean section/Abdominal Surgery ☐Heart Surgery (bypass) ☐Bone/Joint Surgery (total joint replacement, knee, shoulder, or hip)
Other Surgeries: Please List _____

IV. Please list or provide a list of any medications you are currently taking. Include any supplements and/or any over the counter medications.

Name	**Dosage**	**Reason (Heart, Diabetes, Pain, etc)**

V. How many packs of cigarettes do you currently smoke each day on average? Please choose only ONE of the following:
☐Do not Smoke ☐Less than 1 pack per day ☐More than 1 pack per day

VI. How many cups of caffeinated beverage do you drink each day?
1 cup of coffee equals 1 cup 2 cups of tea equals 1 cup 3 cans of soda equals 1 cup.
☐Do not drink caffeine ☐1-2 Cups ☐3 Cups or more

VII. Do you have any allergies to Latex or Steroids? Latex: ☐Yes ☐No Steroids: ☐Yes ☐No

VIII. Have you fallen in the past 12 months? ☐Yes ☐No

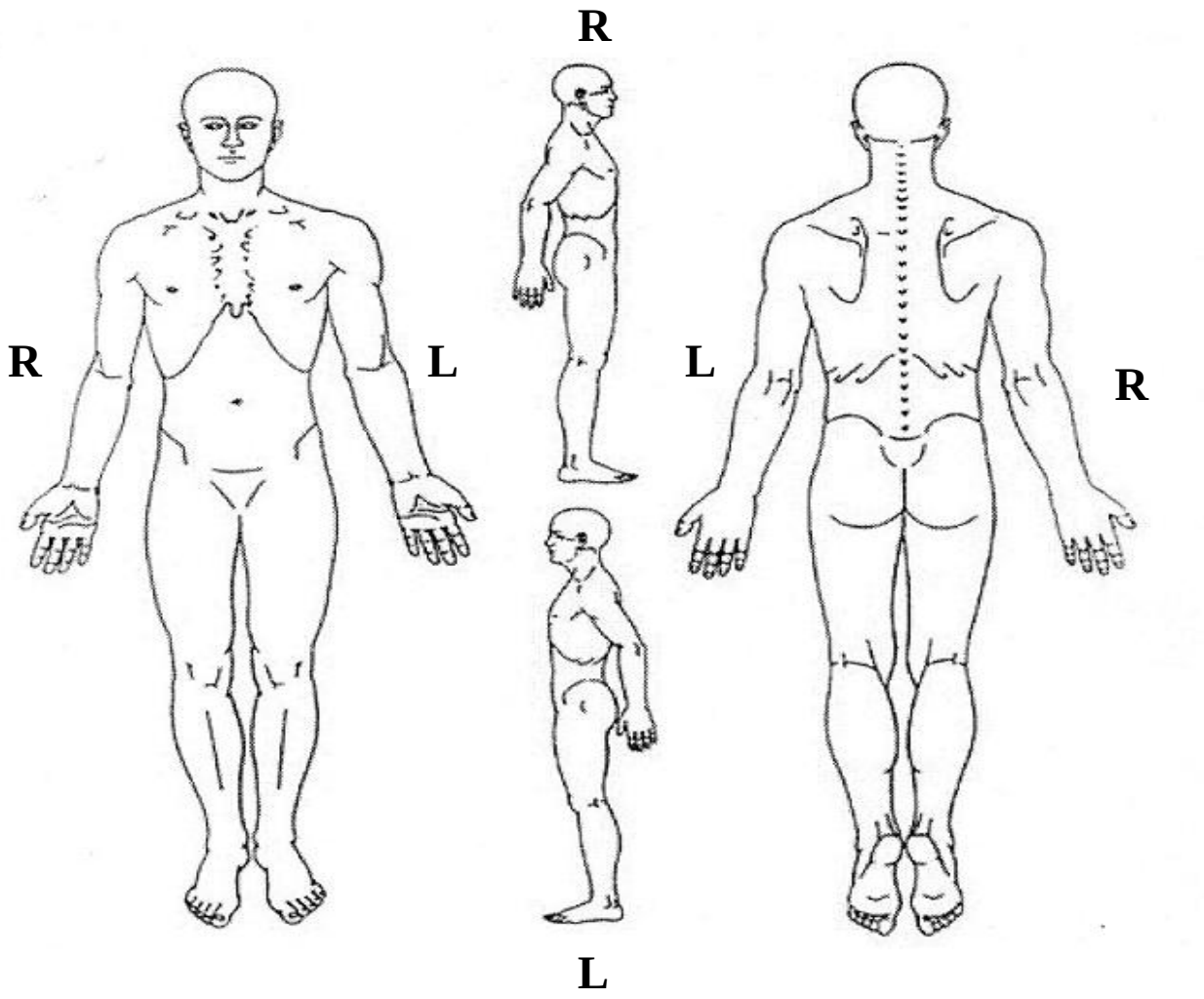
IX. Personal health rating: Excellent☐ Very Good ☐ Good☐ Fair☐ Poor ☐

_____ _____
Patient / Guardian's Signature (verifies that the above information is accurate) **Date**

NOONAN PHYSICAL THERAPY & ASSOCIATES

PAIN SCALE

<u>Please</u> indicate below where your symptoms are located by shading in the areas(s)



Rate your pain (0=no pain, 10 = worst pain imaginable)

Right Now:	*No pain*	0	1	2	3	4	5	6	7	8	9	10	*Worst pain imaginable*
Worst in past week:	*No pain*	0	1	2	3	4	5	6	7	8	9	10	*Worst pain imaginable*
Best in past weeks:	*No pain*	0	1	2	3	4	5	6	7	8	9	10	*Worst pain imaginable*

Describe what kind of pain/symptoms you're having (ie: dull, achy, sharp, tingling, etc.)

_____

_____

_____ _____

Patient Name **Date**

PELVIC THERAPY SYMPTOM QUESTIONNAIRE

Patient Name: _____ Date: _____

Answering the following questionnaire will help us provide you with the best care for your specific needs. Please answer to the best of your ability **prior to your first appointment**.

I. What condition or symptoms are you seeking pelvic therapy for an when did they begin? _____

_____

_____

II. **Do you now or have you ever had a history of the following?**
Explain any checked boxes and include dates if possible on the lines provided below.

- ☐Frequent Bladder Infection
- ☐Blood in Urine
- ☐Constant Dribbling of Urine
- ☐Trouble Feeling Bladder Fullness
- ☐Strong Sense of Bladder Urgency
- ☐Trouble Initiating Your Urine Stream
- ☐Childhood Bladder Problems (please list)
- ☐Straining to Pass Bowel Movements
- ☐Fecal Incontinence (Bowel Accidents)
- ☐Pelvic Pain
- ☐Abdominal Pain
- ☐Low Back Pain or Sciatica (circle)
- ☐High Cholesterol
- ☐HIV/AIDS
- ☐Broken Bones (please list)
- ☐Emphysema / Bronchitis (circle)
- ☐Traumatic Brain Injury
- ☐Parkinson's Disease
- ☐Sexually Transmitted Disease (please list)
- ☐History of Sexual Abuse or Trauma
- ☐Eating Disorder
- ☐Other (please list)

Explanation of the above responses:

_____

_____

_____

III. **Surgical History:**

- ☐Surgery For Your Abdomen
- ☐Surgery For Your Bladder
- ☐Surgery For Your Female Organs
- ☐Surgery For Your Prostrate

Pelvic History: (males only)

- ☐Scrotal Pain
- ☐Testicular Pain
- ☐Pain with Erections/Ejaculation (circle)
- ☐Persistent Erections (day / night) (circle)
- ☐Erectile Dysfunction

OB/GYN History: (females only)

- ☐Pregnancies #_____
- ☐Vaginal Deliveries # _____
- ☐C-Section #_____
- ☐Pregnancy Not Carried to Term #_____
- ☐Difficult Childbirth
- ☐Painful Periods
- ☐Endometriosis
- ☐Uterine Fibroids
- ☐Ovarian Cysts
- ☐Prolapse or Falling Out Feeling
- ☐Pain with Intercourse / Tampons / Pelvic Exam (circle)

Patient Name: _____ Date: _____

IV. **Bladder Habits**

PELVIC THERAPY SYMPTOM QUESTIONNAIRE

How often do you urinate during the day? _____ # of times per day, **or** every _____min / hrs (circle one)
How often do you urinate after going to bed? _____# of times?
Do you take your time to go to the toilet and empty your bladder? Y / N (circle one)
How many bladder infections have you had in the past year? _____
Can you stop the flow of urine when on the toilet? Y / N (circle one)
How much urine do you usually void? Large / Medium / Small / Very Small (circle one)
Are you bothered by a frequent sensation of needing to empty your bladder? Y / N (circle one)
Do you rush to the bathroom to urinate? Y / N (circle one) Do you strain to pass your urine? Y / N (circle one)
Do you empty your bladder "just in case", before you have an urge to urinate? Y / N (circle one)
Do you have the feeling your bladder is still full after urinating? Y / N (circle one)
Do you have difficulty starting your urine stream? Y / N (circle one)
Do you have a slow or hesitant urinary stream? Y / N (circle one)
Do you have "triggers" that make you feel like you can't wait to go to the toilet? Y / N (circle one)
Hearing Running Water / Feeling Cold / Unlocking Front Door / Other _____ (circle all that apply)
How long can you delay the urge to urinate? _____ min **or**_____ hours

V. Bowel Habits

How many bowel movements do you have per day? _____ # of times per day, **or** per week _____
What is the typical consistency of your stool? Normal / Loose / Hard / Varies (circle one)
Do you have a history of constipation? Y / N (circle one)
Do you usually strain to have a bowel movement? Y / N (circle one)
Do you tend to ignore the urge to have a bowel movement? Y / N (circle one)
Do you use Laxatives / Stool Softeners / Enemas / Suppositories / None ? (circle all that apply)
What specifically do you use? _____ How often? _____
Do you ever use insert a finger in the rectum to help you have a bowel movement? Y / N (circle one)

VI. If You Experience Leakage of Urine, Please Answer the Following Questions:

How many episodes of urinary leakage do you experience? _____ # per day / week / month (circle one) **or** *only* with strong cough / sneeze **or** *only* premenstrual (circle one)
With what activities do you lose urine? (circle all that apply below)
Coughing / Sneezing / Laughing / Lifting Vigorous Activity or Exercise (running / weight lifting)
Light Activity (walking / light housework) Light Activity (walking / light housework)
On Way to the Bathroom / With Strong Urges / Hearing Running Water / Sleeping
Changing Positions: Bending / Reaching / Standing up From the Chair / Getting Out of Bed / Getting Out of Car
During Intercourse or Sexual Activity
Other, please list _____
How severe are your leaks? Few Drops / Wets Underwear / Wets Outerwear (circle one)
What protection do you wear for leakage? (circle all that apply below)
None / Tissue or Toilet Paper / Paper Towel / Panty Liner / Mini Pad / Maxi Pad / Diaper / Other _____
Position where leaks have occurred: Lying Down / Sitting / Standing (circle all that apply)

VII. If You Experience Bowel Accidents, Please Answer the Following Questions:

How often do you experience bowel accidents: _____ # times per day / week / month (circle one)
What is the consistency of your bowel accidents? (circle all that apply below)
Liquid / Soft / Firm / Pellets / Mucus / Other_____