**Client Health Questionnaire**

Name Click or tap here to enter text. Age Click or tap here to enter text. Date of Birth Click or tap here to enter text.

Please describe your current complaint or limitation: Click or tap here to enter text.

Please describe *how* and *when* your problem began: Click or tap here to enter text.  
List tests or other interventions for this condition that you have had: Click or tap here to enter text.

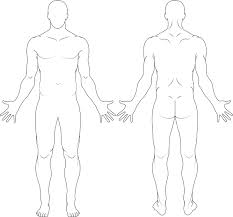
Have you had other physical therapy or speech therapy this year? NO YES - If yes, how many? Click or tap here to enter text.

Please indicate the daily activities that you cannot perform: Click or tap here to enter text.

Did you have surgery for this issue? No Yes Date Click or tap here to enter text. Procedure: Click or tap here to enter text.

Please describe the nature of your symptoms (check **all** that apply): **Please mark locations of pain on the picture**

|  |  |  |
| --- | --- | --- |
| **Dizziness/Imbalance:**  Spinning/vertigo Lightheadedness Imbalance Feeling “off” Motion intolerant Migraine/Headaches Ear Pressure/Pain  Ringing in ears  Changes in hearing  Head Injury/Concussion | **Pelvic Health:**  Leaking urine  Bladder urgency  Leaking bowel  Pain in pelvic region  **Symptom Frequency:**  Constant (76 – 100%)  Frequent (51 – 75%) Occasional (26 – 50%) Intermittent (25% - or less) | **Pain Description:**  Sharp Pain Dull (Pain) Ache  Throbbing Numbness Shooting Burning Tingling |



Level of symptoms at ***worst*** from 0 (No symptoms) to 10 (Unbearable symptoms) Click or tap here to enter text.  
Level of symptoms at ***best*** from 0 (No symptoms) to 10 (Unbearable symptoms) Click or tap here to enter text.  
Activities or positions that increase symptoms:Click or tap here to enter text.

Activities or positions that decrease symptoms: Click or tap here to enter text.

Occupation Click or tap here to enter text.

|  |
| --- |
| Present: Weight \_\_\_\_\_\_ Height \_\_\_\_\_ft \_\_\_\_\_in. Have you fallen in the last year? NO YES - If yes, how many? \_\_\_\_\_\_ |
| Medication: (Name/Dosage/Frequency/Route Administered)  Click or tap here to enter text.  \*\***If you need additional room for medications please bring a separate document on your next visit** |
| Hospitalization/Surgical Procedures (list if not described elsewhere):  Click or tap here to enter text.  Do you have a Pace Maker: NO YES |

PAST PRESENT

 High Blood Pressure

 Angina

 Heart Attack

 Stroke

 Asthma

 HIV/AIDS

 Cancer – Location: Click or tap here to enter text.

 Tumor

 Systemic Lupus

 Hepatitis

 Epilepsy

 Diabetes

 Rheumatoid Arthritis

 Arthritis

 Pregnancy

 Incontinence

 Other Click or tap here to enter text.

 Tobacco Use – packs/day: Click or tap here to enter text.

 Drug or Alcohol Dependence

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the past 2 weeks, how often have you been bothered by any of the following problems?** | **Not At All** (0) | **Several Days** (1) | **More Than Half the Days** (2) | **Nearly Every Day** (3) |
| 1. Little interest or pleasure in doing things |  |  |  |  |
| 1. Feeling down, depressed or hopeless |  |  |  |  |

**INFORMED CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT**

I acknowledge and understand that I have been referred to a pelvic health therapist for an evaluation and treatment of pelvic floor dysfunction and related impairments of the pelvic girdle. I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist(s) or their trained assistant(s) to perform an internal pelvic floor muscle and pelvic girdle examination. This examination will include, but is not limited to assessment of skin condition, reflexes, muscle tone, length, strength, and endurance, scar mobility, and function of the pelvic floor region. It may be necessary to perform an internal pelvic floor evaluation by inserting a gloved finger(s) into the perineal region including the vagina and/or rectum.

Treatment of the pelvic floor region and/or pelvic girdle may include, but is not limited to the following: observation, palpation, use of vaginal weights and other tools, vaginal and/or rectal sensors for biofeedback and/or electrical stimulation, heat, ice/cryotherapy, stretching and strengthening exercises, soft tissue and/or joint mobilization and education instruction.

I understand that I will have the opportunity to give/revoke my consent at each treatment session. Verbal consent will continuously be obtained throughout each session and I am always in control of my own body and what is performed during sessions at physical therapy. I understand that I may request further patient education at any time during my therapy plan of care.

I understand that I have the option to have a second person in the room for the pelvic floor evaluation and treatment (as described above). The second person present, besides myself and the treating/evaluating therapist, can be a friend, family member, or clinic staff member. Please indicate your preference with your initial below:

YES I want a second person present during the pelvic floor evaluation and treatment.

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

I would like to discuss my options with my treating therapist prior to consenting.

Potential Risks: I acknowledge that a full pelvic floor evaluation and/or pelvic floor treatment may increase my current level of pain or discomfort, or an aggravation of my existing injury/symptoms. This discomfort is usually temporary. If it does not subside in 1-3 days, I agree to contact my therapist and/or physician.

Potential Benefits: A full pelvic floor evaluation and/or pelvic floor treatment may improve my symptoms and increase my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance of my pelvic girdle muscles. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition/impairments and will be more aware of the resources available to me.

No Warranty: I understand that the therapist(s) cannot make any promises or guarantees regarding a cure for improvement of my condition. I understand that my therapist(s) will share their opinion with me regarding potential results of physical therapy and will discuss all treatment options before I consent to treatment based on subjective and objective examination findings.

I have informed my therapist(s) of any condition\*\* that would limit my ability to have an evaluation or treatment performed to the perineal/pelvic region including internal palpation of the vagina and/or rectum. I hereby request and consent to the evaluation and treatment to be provided.

By signing below, I agree that I have read and understand the INFORMED CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT, and that I consent to the evaluation and treatment of my pelvic floor/pelvic girdle. Below I will list any concerns, requests, or stipulations necessary to proceed with evaluation and/or treatment that I have consented to:

Patient Signature Click or tap here to enter text. Date Click or tap here to enter text.

***\*\*If you are or may be pregnant, have an infection within or near the pelvic region, have an IUD or other implants, have a sexually communicable disease, are less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity or allergies to lubricant, vaginal creams or latex, please inform the therapist(s) prior to the pelvic floor evaluation and treatment session.***

Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date:** Click or tap here to enter text.

**PATIENT’S NAME:** Click or tap here to enter text.   
 (First) (M.I.) (Last)

**PATIENT’S DATE OF BIRTH:** Click or tap here to enter text. **PATIENT’S SSN**: Click or tap here to enter text.  
  
**PATIENT’S ADDRESS:** Click or tap here to enter text.  
 (Street/PO Box) (City) (State) (ZIP)

**PATIENT’S HOME PHONE:** Click or tap here to enter text. **CELL PHONE:** Click or tap here to enter text.

**EMAIL ADDRESS:** Click or tap here to enter text.

**PATIENT’S EMPLOYER:** Click or tap here to enter text. **PHONE:**Click or tap here to enter text.

**Preferred Contact Method:** PHONE EMAIL TEXT

**Who is the insurance holder:** Click or tap here to enter text. Relation to patient: Click or tap here to enter text.

**Insured’s:** DOB: Click or tap here to enter text. SSN: Click or tap here to enter text. Employer: Click or tap here to enter text.

**Do you wish to receive FYZICAL updates via email?** YES NO

**Marital Status**: Choose an item.  
**Gender/Sex**: Choose an item.  
**Race/Ethnicity**: Choose an item.

**Language Spoken:** Click or tap here to enter text.

**Referring Physician:** Click or tap here to enter text. **Family Physician:** Click or tap here to enter text.

**Have you had any physical, occupational, or speech therapy this year?** YES NO

**How did you hear about us?** Choose an item.

**If you are** **married, please complete the following information:**Spouse’s Name: Click or tap here to enter text. Date of Birth: \_\_/\_\_/\_\_ Cell phone: Click or tap here to enter text.

**If patient is under 18, or under 26 on parent’s insurance, complete the following information for *BOTH* parents:**Father’s Name: Click or tap here to enter text. Mother’s Name: Click or tap here to enter text.  
Address:Click or tap here to enter text. Address: Click or tap here to enter text.  
Phone:Click or tap here to enter text. Phone: Click or tap here to enter text.  
Employer: Click or tap here to enter text. Employer: Click or tap here to enter text.\_  
Work Phone: Click or tap here to enter text. Work Phone: Click or tap here to enter text.  
SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_   
Cell Phone:Click or tap here to enter text. Cell Phone: Click or tap here to enter text.

101 Tower Rd #210

Dakota Dunes, SD 57049

(605) 217-4330

**AUTHORIZATION FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND ASSIGNMENT OF BENEFITS**

* Our office is happy to file your insurance claims for you. Please provide your insurance card and photo ID. You are required to pay your copay today upon checking out.
* If you do not have your insurance card, you will be required to prepay $200 and arrange payments for any remaining balance. Once you have supplied your insurance information, we will file your claim and refund you according to your benefits.
* If you do not have insurance coverage, you will be required to prepay $200 and must be prepared to make arrangement for any remaining balance with a post-dated check or visa/master card number upon checking out.
* My signature below gives Ear Nose and Throat Consultants/FYZICAL, and all providers within, my consent for treatment by means providers consider necessary and proper treatment of the identified patient. This treatment may require diagnostic procedures, audiology testing, laboratory testing and x-rays.
* My signature below authorizes ENT Consultants/FYZICAL to release or disclose information to the insurance companies and/or outpatient programs from my medical record pertaining to my treatment as needed to process claims.
* My signature below acknowledges that I am aware and financially responsible to ENT Consultants/FYZICAL for any and all charges not covered by this assignment.

**Print Patient Name** Click or tap here to enter text. **Date of Birth** Click or tap here to enter text.

**X**Click or tap here to enter text. Click or tap here to enter text.

**Signature of patient / parent / or guardian Today’s Date**

**HIPAA CONSENT FORM**

I authorize Ear Nose and Throat Consultants and Hearing Services, PLC to release information that does contain private health information including but not limited to the following services: exams, lab and test results, prescription, purchased products, scheduling of appointments and scheduling surgery. You *must* check mark anyone who you want to be able to obtain information about you and your health. If you have been referred here by another physician, exam results will be sent to them automatically. I acknowledge I have been offered a copy of the Privacy Statement and I have no further questions.

**Release information to:** Choose an item.

Significant other (name) Click or tap here to enter text. Caregiver (name) Click or tap here to enter text.

Interpreter (name) Click or tap here to enter text. Telephone number Click or tap here to enter text.

In the event of an ***EMERGENCY,*** or if we are unable to reach you, please list someone ***outside of your household***

Name: Click or tap here to enter text. Telephone: Click or tap here to enter text.

By checking this box, I consent to have my FYZICAL medical records shared with my primary care provider.

**X** Click or tap here to enter text. Click or tap here to enter text.  
**Signature of patient / parent/ or guardian Today’s Date**

\*\*\*form valid for one year from today’s date

**NOTICE OF PRIVACY PRACTICES**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, initiate payment, or conduct health care operations for other purposes permitted or required by law. The medical practice reserves the right to make changes in the Notice of Privacy Practices. The Notice describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health condition and related health care services.

For a more complete and detailed version of this privacy practice notice, make your request known at the front desk.

We understand that medical information about you and your health is personal, and we are committed to protecting it. A record of the care and services you receive at this practice is created and maintained at this location.

We are require by law to:

* Make sure that medical information that identifies you is kept private
* Provide you this notice of our legal duties and privacy regarding your medical information
* Follow the term of the notice that is currently in effect

The following categories describe ways that we use and disclose medical information about you:

* Treatment
* Payment
* Healthcare operations
* Third party business associates such as billing or transportation

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternative or other health-related benefits and services that may be of interest to you. Your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our privacy officer to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician’s practice has taken action in reliance on the use or disclosure indicated in the authorization.

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclose of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly related to that person’s involvement in your healthcare. We may use or disclose your protected health information in an emergency treatment situation.

We may use or disclose your protected health information in the following situations without your consent or authorization:

* Required by law
* Public health
* Communication diseases
* Health oversight
* Abuse or neglect
* Food and Drug Administration
* Legal proceeding
* Law enforcement
* Coroners, funeral directors, and organ donation
* Worker’s compensation
* Inmates
* Sale of closure of the practice

Your rights:

* Inspect and copy your protected health information
* Request a restriction of your protected health information
* Request to receive confidential communications from us by alternative means or location
* Have your physician amend your protected health information
* Receive an accounting of certain disclosures we have made, if any
* Receive a paper copy of this notice from us
* File a complaint

You may file a complaint to our office or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. You will not be penalized or retaliated against for filing a complaint.

Ear Nose and Throat Consultants and Hearing Services, PLC

101 Tower Rd #120, Dakota Dunes, SD 57049

(605) 217-4320