

PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms

Your answers to the following questions will help us to manage your child's care better. Please complete all pages prior to your child's appointment.

Name of parent or guardian completing this form _____

Child's name: _____ Prefers to be called _____ Date: _____

Age _____ Grade _____ Height _____ Weight _____

Describe the reason for your child's appointment _____

When did this problem begin? _____ Is it getting better _____ worse _____ staying the same _____

Name and date of child's last doctor visit _____ Date of last urinalysis _____

Previous tests for the condition for which your child is coming to therapy. Please list tests and results _____

<u>Medications</u>	<u>Start date</u>	<u>Reason for taking</u>
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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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. _____

Does your child now have or had a history of the following? Explain all "yes" responses below.

Y/N Pelvic pain _____ Y/N Blood in urine _____

Y/N Low back pain _____ Y/N Kidney infections _____

Y/N Diabetes _____ Y/N Bladder infections _____

Y/N Latex sensitivity/allergy _____ Y/N Vesicoureteral reflux Grade _____

Y/N Allergies _____ Y/N Neurologic (brain, nerve) problems _____

Y/N Asthma _____ Y/N Physical or sexual abuse _____

Y/N Surgeries _____ Y/N Other (please list) _____

Explain yes responses and include dates _____

Does your child need to be catheterized? Y/N If yes, how often? _____

Bladder Habits

1. How often does your child urinate during the day? _____ times 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? Y/N If yes, _____ days per week.

4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y/N

5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)

___ Not at all _____ 11-30 minutes

___ 1-2 minutes _____ 31-60 minutes

___ 3-10 minutes _____ Hours

6. Does your child take time to go to the toilet and empty their bladder? Y/N

7. Does your child have difficulty initiating the urine stream? Y/N

8. Does your child strain to pass urine? Y/N

9. Does your child have a slow, stop/start or hesitant urinary stream? Y/N
10. Is the volume of urine passed usually: Large Average Small Very small (circle one)
11. Does your child have the feeling their bladder is still full after urinating? Y/N
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? Y/N
13. Fluid intake (one glass is 8 oz or one cup)
 - ___ of glasses per day (all types of fluid)
 - ___ of caffeinated glasses per day
 - Typical types of drinks _____
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e. running water, etc.) Y/N please list _____

Bowel Habits

15. Frequency of movements: ___ per day _____ per week. Consistency: loose___ normal___ hard___
16. Does your child currently strain to go? Y/N_____ Ignore the urge to defecate? Y/N_____
17. Does your child have fecal staining on his/her underwear? Y/N How often?_____
18. Does your child have a history of constipation? Y/N_____ How long has it been a problem?_____

SYMPTOM QUESTIONNAIRE

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Bladder leakage (check all that apply) <ul style="list-style-type: none"> ___ Never ___ When playing ___ While watching TV or video games ___ With strong cough/sneeze/physical exercise ___ With a strong urge to go ___ Nighttime sleep wetting 2. Frequency of urinary leakage-number (#) of episodes <ul style="list-style-type: none"> ___ # per month ___ # per week ___ # per day ___ Constant leakage 3. Severity of leakage (circle one) <ul style="list-style-type: none"> ___ No leakage ___ Few drops ___ Wets underwear ___ Wets outer clothing 7. Protection worn (circle all that apply) <ul style="list-style-type: none"> ___ None ___ Tissue paper / paper towel ___ Diaper ___ Pull-ups | <ol style="list-style-type: none"> 4. Bowel leakage (check all that apply) <ul style="list-style-type: none"> ___ Never ___ When playing ___ While watching TV or video games ___ With strong cough/sneeze/physical exercise ___ With a strong urge to go 5. Frequency of bowel leakage-number (#) of episodes <ul style="list-style-type: none"> ___ # per month ___ # per week ___ # per day 6. Severity of leakage (circle one) <ul style="list-style-type: none"> ___ No leakage ___ Stool staining ___ Small amount in underwear ___ Complete emptying |
|--|---|
8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10

0 _____ 10

Not a problem Major problem
 9. Rate the following statement as it applies to your child's life today

My child's bladder is controlling his/her life.

0 _____ 10

Not true at all Completely true

PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also 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 or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction. Treatment may also include _____

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist.

Potential benefit: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:

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

Cooperation with treatment:

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of \$ _____

No warranty: I understand that the 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 potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of _____

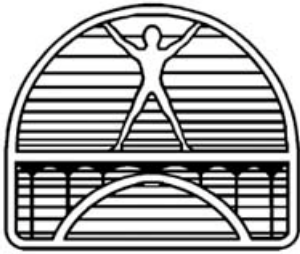
Date _____

Patient Name: _____
(Please Print)

Patient Signature

Signature of Parent or Guardian (If applicable)

Witness Signature



FOLSOM PHYSICAL THERAPY *and Training Center*

Consent to Treat

Were you injured on the job?	YES	NO
Have you filed a work comp claim?	YES	NO
Were you injured in a motor vehicle accident?	YES	NO
Is this injury involved in litigation?	YES	NO

If you have an attorney, please fill out the following:

Name of Attorney: _____ Phone#: _____

Address: _____

***We do not accept liens against pending legal settlements.**

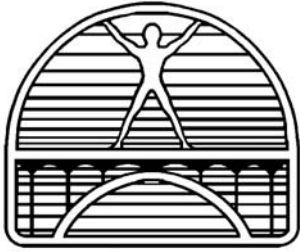
Missed appointments are a loss for everyone. Please notify us as soon as possible if you cannot keep your scheduled appointment. We require **(a minimum) 24-hour cancellation notice** to allow us time to fill your appointment time. **Cancellations or missed appointment (“no shows”) without at least a 24-hour notification are subjected to a \$25.00 fee.**

I, _____, have read and understand that I remain responsible for
(PRINT NAME HERE)

the total amount due to Folsom Physical Therapy for their services and policies, such as that listed above. I, the undersigned, do hereby agree and give my consent to Folsom Physical Therapy to furnish medical care and treatment considered necessary and proper in assessing or treating my physical condition.

I hereby assign all medical benefits to Folsom Physical Therapy and authorize release of all information necessary to secure payment. A photocopy should be considered valid.

Signature: _____ Date: _____



FOLSOM PHYSICAL THERAPY *and Training Center*

Financial Policy

We are committed to providing you the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial payment policy.

Payment is due at the time of service unless special payment arrangements have been approved in advance by our staff. We accept cash, checks, Visa, and MasterCard. We will be happy to process to your insurance claim for reimbursement. However, **it is the patient's responsibility to familiarize themselves with their own insurance policy and understand their terms and coverage thoroughly regarding physical therapy.**

Returned checks and balances older than 30 days may be subjected to additional collection fees and interest. Charges will be made for cancellations or missed appointment ("no shows") without a minimum 24-hour notification.

We will be happy to discuss your questions and concerns relating to your specific physical therapy coverage. You must realize, however, that:

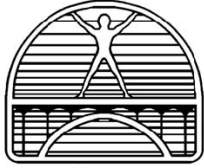
- Your insurance is a contract between you, your employer, and the insurance company; we *are not* a party to that contract.
- Our fees are generally considered to fall within the acceptable range by most insurance companies and, therefore, are covered up to the maximum allowance determined by each carrier.
- This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost and care in this area.
- Not all services are covered benefit in all contracts. We suggest you find out if physical therapy is covered under your insurance contract.

We must emphasize that, as physical therapy providers, our relationship is with you, the patient, and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions regarding the above information, please do not hesitate to ask us.

I, _____, have read and understand the above Financial Policy.
(PRINT NAME HERE)

(Patient/Guardian)Signature: _____ Date: _____



FOLSOM PHYSICAL THERAPY
and Training Center
Medical Release Authorization

To Whom It May Concern:

I, _____, hereby give my consent for Folsom Physical Therapy to release my Protected Health Information (PHI) including physical therapy notes, dates of services, and diagnosis codes, to/from the following person(s)/facilities:

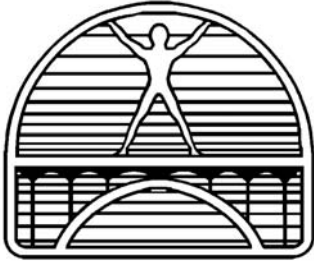
Effective dates: _____ - _____

This authorization may be revoked at any time by delivering a signed Restriction Request Form to our business office at Folsom Physical Therapy.

Sincerely,

Signature

Date



FOLSOM PHYSICAL THERAPY
and Training Center

Privacy Practice Document

- This notice describes how medical information about you, the patient, may be used and disclosed. It also explains how you can get access to this information. **Please review it carefully.**

Our commitment here at *Folsom Physical Therapy* is to serve our patients with professionalism and care, while protecting the privacy and security of all Protected Health Information at all times.

During the course of serving your interests, it may be necessary to share information with other health care providers or business associates. Examples of such instances are described below:

- We may request from your physician MRI's, X-Rays, operation reports and other information that would be helpful in the course of your treatment.
- We use the services of an independent billing company, and so medical information will be passed along to them for billing and payment purposes.

We, here at *Folsom Physical Therapy*, are committed to obeying all federal, state, and local laws regarding privacy practices. If any other uses or disclosures other than those listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your protected health information, please contact our compliance officer, **Darlene, at (916) 388-8500.**

I, _____, have read and understand the above Notice of Privacy Practices.
(PRINT NAME HERE)

(Patient/Guardian) Signature: _____ **Date:** _____