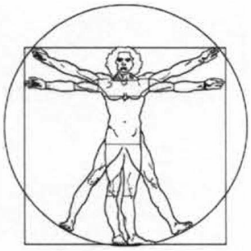


Lake County Physical Therapy LLC

1721 Moon Lake Boulevard Suite 105, Hoffman Estates, IL 60169 224-653-9989

511 E Hawley St, Mundelein, IL 60060 847-543-7604

3535 E New York St, Suite 117 Aurora, IL 60504 630-978-8763

Dear Valued Client:

Thank you for choosing **Lake County Physical Therapy LLC** for your physical therapy needs. We appreciate your business and look forward to exceeding your expectations. If you have any questions, please do not hesitate to ask the therapist or staff. We look forward to partnering with you on your road to full recovery.

The following pages are for you to fill out legibly and accurately. The first page is a signature page that you have seen a copy of the HIPPA Notice of Privacy Practice. If you wish to have a written copy, please ask our staff. The second page is for billing and demographic information. The third page is a questionnaire regarding your medical history. And following is a page for you to map your area(s) of pain on the drawing.

Please inform us when you have an appointment with your referring physician so we can update them on your progress.

It is very important that you maintain your scheduled appointments and not stop coming when you start to feel a little better. Discontinuing the therapy could hurt you in the long run. If you need to reschedule your appointment, please give us at least 24 hours notice or you may be subject to a no-show/cancellation charge of $35.00.

Co-payments are expected at the time of service. You will be advised of your co-pay after we verify your insurance. We understand that co-pays can be significant. If you cannot make full payment for your co-pays at the time of service, please contact our billing department to make arrangements.

We encourage you to contact your insurance company to verify your coverage and benefits.

We pledge to give you prompt, efficient, courteous service rendered by a licensed Physical Therapist. We welcome your comments and suggestions and want to take this opportunity to welcome you to your first therapy session.

Sincerely,
The Staff of Lake County Physical Therapy

→ Is your condition/injury the result of a motor vehicle accident / a work related accident / or any other accident?.....Yes / No If yes, date:_____

I _____; (PRINT NAME) have read this page and agree with the requirements stated and acknowledge responsibility for the above items.

_____ Signature _____Date

Allow Us To Exceed Your Highest Expectations!

Pelvic Floor Health Information Sheet

Welcome to your first pelvic floor health physical therapy visit. At your first session, your therapist may perform the following evaluations:

- Posture Assessment
- Evaluation of abdominal, lower back and leg muscles
- Observation and assessment of your pelvic area and rectum
- Internal evaluation of your pelvic floor muscles strength, sensation and integrity. You will contract around the therapist's finger in order to test your ability to recruit your pelvic floor muscles. **No devices or equipment will be used in this assessment.**
- Evaluation of any muscular or joint complex that may be contributing to the presence of your condition.

After the initial visit, you will be scheduled to return based on your needs and the evaluation results. Your active involvement in therapy is essential to improve your health and meet your goals.

If you have any questions or concerns, please do not hesitate to speak with us.

Sincerely,

The Pelvic Floor Health Therapists of Lake County Physical Therapy

"Allow Us To Exceed Your Highest Expectations!"

I hereby authorize the therapist at Lake County Physical Therapy LLC to perform the evaluation and treatments that they consider necessary for my benefit.

Printed Name_____ Date_____

Signature_____ Date_____

WE CARE!!

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

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, bladder or sexual dysfunctions, painful scars after surgery or childbirth (women), persistent sacrolilliac or low back pain, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the pelvic region including the rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal (women) or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to the following: observation, palpitation, use of vaginal weights (women), vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

I understand that in order for the 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 exercise program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having discomfort or unusual symptoms during the procedure.
4. I have the option of having a second person present in the room during the procedure and _____ choose _____ refuse this option.

Patient Name_____ Date_____

Patient Signature_____

Signature of Parent or Guardian (if applicable)_____

Witness Signature_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Lake County Physical Therapy, LLC.

_____ _____
Signature Date

In lieu of patient signature, I _____, a staff member of Lake County Physical Therapy, state that _____ has been given our current Notice of Privacy Practices.

_____ _____
Signature Date

LAKE COUNTY PHYSICAL THERAPY, LLC

First Name_____ Last Name_____

Date of Birth_____ Social Security#_____

Email Address:_____
(This is needed so we can send you newsletters, your therapy information or updates. **This will never be sold or shared**!)

Address_____

City_____ State_____ Zip_____

Home Phone#_____ Work Phone #_____

Cell Phone#_____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referring Physician_____ Physician Phone#_____

Primary Care Physician_____ P.C.P. Phone#_____

Onset Date_____ Physician Appointment_____

If you have more than one insurance carrier, please indicate which is primary and which is secondary. **IT IS YOUR RESPONSIBILITY TO INFORM US IF YOUR COVERAGE IS CONTINGENT UPON A SECOND OPINION OR PRIOR APPROVAL OF YOUR INSURANCE CARRIER**. We will make a photocopy of your insurance cards so please have them available.

Primary Insurance_____ Secondary Insurance_____

Card Holder's Name if Other than Self_____ Relationship_____

Card Holder's SS#_____ Card Holder Birth Date_____

I hereby authorize Lake County Physical Therapy LLC to perform treatments and procedures that they consider necessary for my benefit, upon consultation with my representative or me. I understand that I am financially responsible for any balance not covered by insurance. *I understand that there may be a $35.00 no show/cancellation charge if I fail to show up or call 24 hours in advance.*

Medicare Patient's Certification, Authorization to Release Information, Payment Request

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I request that payment of the authorized benefits be made to Lake County Physical Therapy LLC on my behalf.

Insurance Patient's Certification, Authorization to Release Information, Payment Request.

Insurance Patient's Certification, Authorization to Release Information, Payment Request

I certify that the information given by me in applying for payment under the provisions of my medical insurance is correct. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to Lake County Physical Therapy LLC.

Patient Signature or Authorized Representative_____ **Date**_____

Lake County Physical Therapy Pelvic Floor Health Questionnaire

NAME: _____ DATE: _____

Do you currently have or have had a history of the following:

Yes	No	Bladder infections	Yes	No	Pelvic Pain
Yes	No	Painful Intercourse	Yes	No	Constipation
Yes	No	Low Back Pain	Yes	No	Stroke
Yes	No	Sexually Transmitted Disease	Yes	No	Smoking
Yes	No	Diabetes	Yes	No	*Vaginal (women) or Rectal Bleeding*
Yes	No	Neurological Disease/Seizures	Yes	No	*Cancer*
Yes	No	Any Infection	Yes	No	*Urinary Retention*
Yes	No	Kidney Stone	Yes	No	*Pacemaker*
Yes	No	Recent Weight Change	Yes	No	*Heart Arrhythmia*

FEMALES: Are you pregnant?	Y	N	If YES, weeks:
Had any Chiropractic visits this year?	Y	N	If YES, when:
Had massage at a Chiropractor this year?	Y	N	If YES, when:
Have you had Home Health this year?	Y	N	If YES, when:
Is a Nurse currently seeing you at home?	Y	N	If YES, when:
Have you ever had Physical, Occupational or Speech Therapy before?	Y	N	If YES, when:

What is your main problem and when did it begin?

_____

_____

How does this problem affect your life & what can you not do because of it?

_____

Please list all past surgeries including the dates:

_____

_____

Please list your current medications and or please note any allergies or allergic reactions:

_____

_____

What was the date of your last pelvic exam? _____

Have you had any special testing done? _____

Do you have pain? YES NO If Yes, please answer next question.

What makes it worse and what makes it better?

_____

Do you have urinary leakage? YES NO

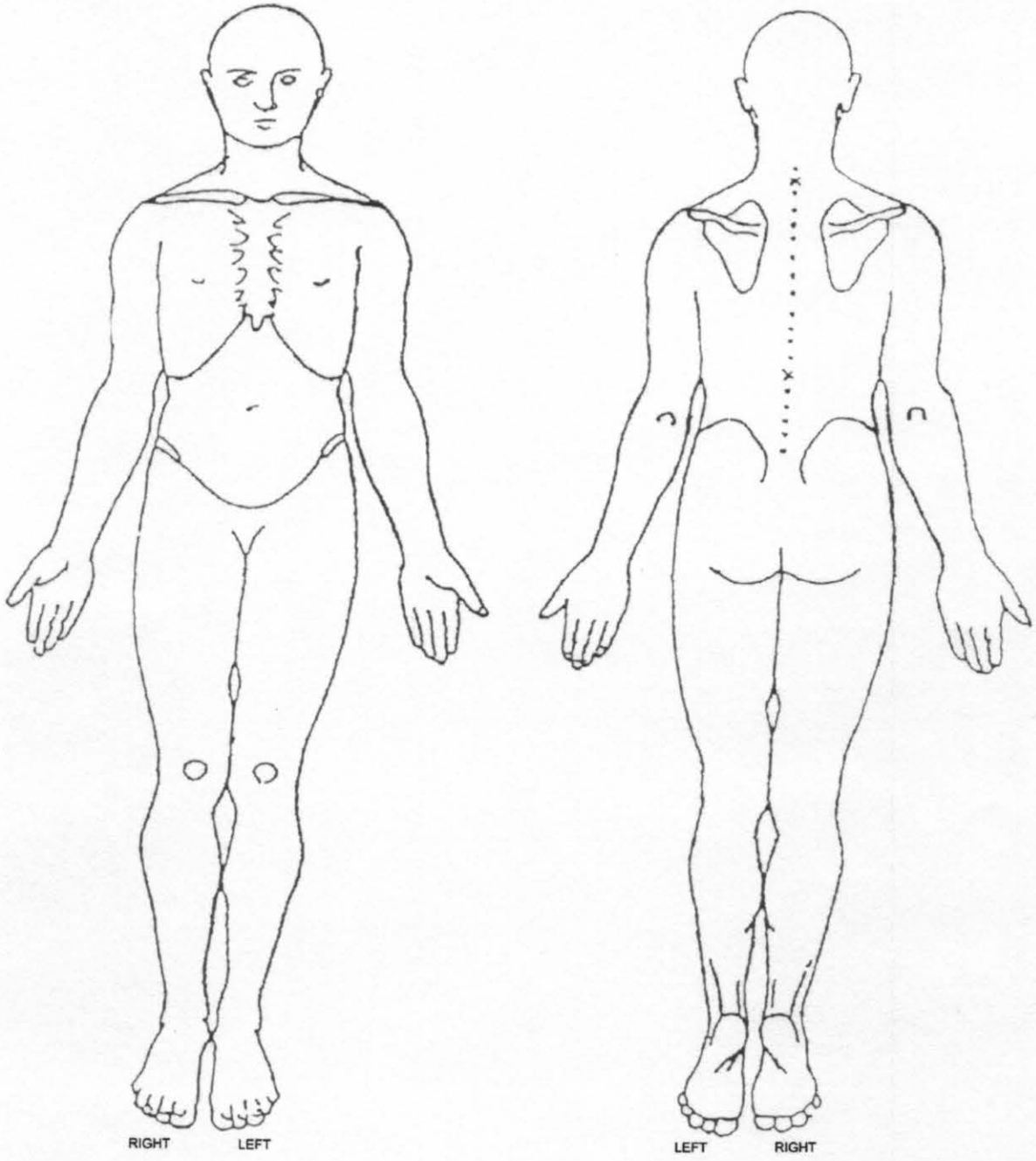
What are your goals for physical therapy?

_____

_____

WE CARE!!

PLEASE SHADE IN THE AREA OF THE BODY DIAGRAM BELOW INDICATING WHERE YOU HAVE PAIN:



Lake County Physical Therapy Pelvic Floor Health Outcome Tool

PATIENT NAME:

_____

DATE: _____

DOB: _____

1) Does your pain interfere with your daily activities?
   A. Not at all
   B. Rarely
   C. Occasionally
   D. Often
   E. Always

2) Does pain interfere with your sex life?
   A. Not at all
   B. Rarely
   C. Occasionally
   D. Often
   E. Always

3) Does your pain wake you up at night?
   A. Never
   B. Not very often
   C. Once a week
   D. Once a night
   E. Many times at night; ___#

4) Do you have pain with urination?
   A. Not at all
   B. Rarely
   C. Occasionally
   D. Often
   E. Always

5) How often do you use the bathroom at night?
   A. Never
   B. 1
   C. 2
   D. 3
   E. 4+

6) Do you leak urine?
   A. Never
   B. Once a month
   C. Once a week
   D. Once a day
   E. Multiple times a day; ___#

7) Do you wear protection because of leaks?
   A. None
   B. ___# Pantiliner (women)
   C. ___# Maxi Pad (women)
   D. ___# Brief/Depends

8) How long can you delay the need to urinate?
   A. 2 hours or greater
   B. 1 hours
   C. 15-30 minutes
   D. Less than 15 minutes
   E. Not at all

9) How much confidence do you have with managing your problem?
   A. I have excellent confidence.
   B. I have good confidence.
   C. I have some confidence.
   D. I have little confidence.
   E. I have no confidence.

Please write additional comments regarding your issue:

_____
_____
_____
_____
_____
_____
_____
_____
_____

SCORE:_____ Out of 44

Max Score 44 = Greatest Impairments

Initial number

ICIQ-UI Short Form

CONFIDENTIAL

DAY MONTH YEAR

Today's date

Many people leak urine some of the time. We are trying to find out how many people leak urine, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

1 Please write in your date of birth:

DAY MONTH YEAR

2 Are you *(tick one)*: Female ☐ Male ☐

3 How often do you leak urine? *(Tick one box)*

never ☐	0
about once a week or less often ☐	1
two or three times a week ☐	2
about once a day ☐	3
several times a day ☐	4
all the time ☐	5

4 We would like to know how much urine <u>you think</u> leaks.
How much urine do you <u>usually</u> leak (whether you wear protection or not)?
(Tick one box)

none ☐	0
a small amount ☐	2
a moderate amount ☐	4
a large amount ☐	6

5 Overall, how much does leaking urine interfere with your everyday life?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

ICIQ score: sum scores 3+4+5 ☐☐

6 When does urine leak? *(Please tick all that apply to you)*

never – urine does not leak	☐
leaks before you can get to the toilet	☐
leaks when you cough or sneeze	☐
leaks when you are asleep	☐
leaks when you are physically active/exercising	☐
leaks when you have finished urinating and are dressed	☐
leaks for no obvious reason	☐
leaks all the time	☐

Thank you very much for answering these questions.

Urogenital Distress Inventory (UDI-6 short form): UDI-6

1) Do you usually experience frequent urination? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

2) Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

3) Do you usually experience urine leakage related to coughing, sneezing, or laughing? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

4) Do you experience small amounts of urine leakage (that is, drops)? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

5) Do you experience difficulty emptying your bladder? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

6) Do you usually experience pain or discomfort in the lower abdomen or genital region? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

   If yes, then is your pain relieved after emptying your bladder? ☐ No ☐ Yes

Scoring ????

Incontinence Severity Index: ISI

How often do you experience urinary leakage?

1. less than once a month
2. a few times a month
3. a few times a week
4. every day and or night

How much urine do you lose each time?

1. drops
2. small splashes
3. more

Score = multiply results from 1 and 2, out of 12

1-2 = slight
3-6 = moderate
8-9 = severe
12 = very severe