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____

_____

_____

_____

Medications	Start date	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 Low back pain
Y/N Diabetes
Y/N Latex sensitivity/allergy
Y/N Allergies
Y/N Asthma
Y/N Surgeries

Y/N Blood in urine
Y/N Kidney infections
Y/N Bladder infections
Y/N Vesicoureteral reflux Grade ____
Y/N Neurologic (brain, nerve) problems
Y/N Physical or sexual abuse
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
___ 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? 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

1. Bladder leakage (check all that apply)
   ___ 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
   ___ # per month
   ___ # per week
   ___ # per day
   ___ Constant leakage
3. Severity of leakage (circle one)
   ___ No leakage
   ___ Few drops
   ___ Wets underwear
   ___ Wets outer clothing
4. Bowel leakage (check all that apply)
   ___ 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
   ___ # per month
   ___ # per week
   ___ # per day
6. Severity of leakage (circle one)
   ___ No leakage
   ___ Stool staining
   ___ Small amount in underwear
   ___ Complete emptying
7. Protection worn (circle all that apply)
   ___ None
   ___ Tissue paper / paper towel
   ___ Diaper
   ___ Pull-ups
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

CONSENT

Condition and Consent for Evaluation and Treatment of Pelvic Floor Dysfunction

I acknowledge and understand that I have been referred to In Balance Physical Therapy & Pelvic Health, LLC 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 functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, and vulva 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 palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. I understand that this evaluation and/or treatment could potentially elicit pain or discomfort. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Your physical therapist is female. No chaperone will be provided during your physical therapy evaluation and treatment sessions unless you request a chaperone to be present. You may choose to bring a friend or family member during the physical therapy evaluation or treatment at any time.

Treatment may include, but not be limited to the following: observation, palpation, use of vaginal weights, 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 no guarantees have been or can be provided regarding the success of therapy. 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 In Balance Physical Therapy & Pelvic Health, LLC.

Conditions:

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

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 $50.

_____ Patient Signature

_____ Patient Name (Please Print)

_____ Signature of Parent or Guardian (If applicable)

Assignment of Benefits

By signing below you are verifying your consent to allow your insurance carrier to make payments directly to In Balance Physical Therapy at 21 Crossroads Drive, Ste 210, Owings Mills, MD 21117 for all services rendered at the same location. You are also confirming that you have are aware that the verification of benefits is not a guarantee of payment by your insurance carrier and any claims unpaid by your insurance become your responsibility.

_____ **Patient's Signature** **Date**_____

In Balance Physical Therapy Authorization for Use, Disclosure or Release of Protected Health Information and/or Medical Records

I hereby request and authorize the use, disclosure and/or release by In Balance Physical Therapy and its employees of medical records and/or medical information, including my social security number (if I gave it at admission) or other protected health information as described below:

Patient's name: _____ **Date of Birth:** _____
Patient's address: _____ **Patient's Phone #:** _____

Please identify who is to receive the medical records or other health information that may be used or released:

_____

Please describe specifically what medical records or other health information may be used or released:

_____

Unless the "No" box is marked, this Authorization extends to such psychiatric, mental health, and drug and alcohol abuse treatment information, if any, as may be contained in said medical record including information protected by I.C. 16-39-1-9, I.C. 16-39-2-1 through 16-39-4-2 and I.C. 16-41-8-1. This release permits re-disclosure in accordance with 42 C.F.R., Part 2, which is a federal regulation governing release and use of medical information pertaining to treatment for alcohol and drug abuse. ☐ NO

Unless the "No" box is marked, the Authorization also extends to information regarding communicable diseases, including human immunodeficiency virus (HIV), and AIDS related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record. ☐ NO

I understand that upon release and disclosure of the protected medical records and information, the records and information may by subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that In Balance Physical Therapy will not deny treatment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to In Balance Physical Therapy. The revocation will be effective upon receipt by In Balance Physical Therapy, except to the extent that In Balance Physical Therapy has taken action in reliance on this authorization.

I understand that there may be a charge to cover actual costs incurred by In Balance Physical Therapy up to $15.00 in preparing and delivering the information requested in this authorization, in accordance with Maryland statutes and In Balance Physical Therapy policies.

Signed: _____ **Date:** _____ **Printed name:** _____

Signed if legal representative: _____ **Date:** _____ **Relationship to the patient:** _____
Printed name: _____

Witness: _____ **Date:** _____

HIPAA Notification

Health Insurance Portability and Accountability Act

Notice of Privacy Practices

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice. If you would like detailed information regarding how we may use and disclose medical information about you and your individual rights regarding your medical information, please let us know and you will be provided with a copy of our Privacy Practices.

Patient Statement

I am aware that this practice, as required by law, maintains the privacy of protected health information as prescribed by HIPAA and that I have access to its provisions. I have been provided an opportunity to review the Notice of Privacy Practices. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in the Notice. I may revoke this authorization at any time in writing.

Print Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

In Balance Physical Therapy: FINANCIAL POLICY

Welcome to our clinic. We are so happy to be able to help you with your pelvic health concerns. Our skilled therapists have had specialized and advanced training to assist you through your recovery process. We pride ourselves in spending one on one, quality time with each of you. If we can ever be of further assistance please don't hesitate to talk with us. We feel fortunate to take this journey to recovery with you.

Please carefully read the following and then initial in the space provided near each paragraph, and then sign below.

1) ____ Health Insurance Participation: In Balance Physical Therapy participates with many, but not all health insurance plans. If we do participate with your health insurance plan, you must present a valid insurance identification card at check-in. Without a valid insurance card, or if we do not participate in your health insurance plan, you will need to speak with the office manager or owner prior to treatment.

2) ____ Co-Payments/Co-insurance: Some insurance plans require payment of a Co-pay or Co-insurance. Payments are due at check-in or check-out. Payments may be made by check, cash, MasterCard or VISA.

3) ____ Referrals: Some insurance plans require a written referral from a primary care provider. Referrals must be presented at check-in. Having a valid referral is a patient's responsibility. It is your responsibility to know how many visits are allowed on your referral and the expiration date of your referral. Without a valid referral if you need one for your insurance, you may reschedule your appointment or payment for your visit will be due upon treatment.

4) ____ Financial Responsibility: Patients are responsible for all co-payments, deductibles, and charges not covered by health insurance.

5) ____ Deductibles: If you have a large deductible ($500/contract year or more) that has not yet been met, you will pay $40.00 per visit up front until you receive your Explanation of Benefits (EOB) from your insurance company. Once your EOB has been sent and the exact amount due is learned, you will be responsible for the remainder of your deductible (if any) at that time. If you have overpaid on your deductible, you will be reimbursed within 7 to 14 days of IBPT receiving your EOB from your insurance company.

6) ____ Account Balances: All outstanding balances must be paid at time of check-in, or if you need, you may set up a payment plan with the office manager or owner. Bills are mailed out every 30 days. Failure to pay any outstanding balances will result in a $15 late fee per month and this fee is owed by you and cannot be billed to your insurance company. Continued failure to not pay outstanding balances in a timely manner may result in the practice forwarding your account to a Collection Agency or Collection Attorney of our choice. This action may result in additional fees, including an administrative fee of 30%. Again, you may set up a payment plan with the owner, and this will be set up on an individual basis. You will be given plenty of fair notice prior to any balance being sent to a Collection Agency.

7) ____ Cancellation/No-Show: We require a minimum of 24 hour notice if you cannot keep your appointment. If you cancel less than 24 hours before your appointment, or miss the appointment all together, there will be a charge of $50. This fee is due at your next visit. If you are able to reschedule your appointment within the same week, we will waive the cancellation fee for that visit. If there are no available appointment times for the appointment to be rescheduled, then the fee will not be waived. Appointments scheduled for a Monday, must be cancelled by the close of business day on Friday (5:00pm). We cannot accept cancellations via e-mail. Appointments cancelled by voicemail over the weekend will still be subject to the $50 cancellation fee. This charge is to cover expenses incurred by our office because of your missed appointment. Due to our specialized services, we have a long waiting list for patients to be seen. Your missed appointment would have given another patient the opportunity to be treated.

IBPT strives to provide each patient with the highest quality of care while attempting to accommodate your schedule. Your consistent attendance of the planned treatment regimen is paramount to your full recovery. We thank you so much for your cooperation!

I (the client of In Balance Physical Therapy) have read and understand the office policies explained above:

Signature: _____ **Date:** _____

Print name: _____

OFFICE USE ONLY – DO NOT SIGN:

Therapist who reviewed financial policy with this client:
(Print Name): _____ Signature: _____ Date: _____