

Duffy & Bracken

WELLNESS & FITNESS • PHYSICAL THERAPY, P.C.

Dear Patient,

Welcome to Duffy & Bracken Physical Therapy. I am thrilled that you have chosen our practice.

Our mission is to have patients who are no longer suffering from their initial complaint, whose health has greatly improved, and who know they have been helped.

We have an excellent and experienced staff that loves to help people get better and will do their best to accomplish **your** goal.

I would like to give you an overview of the therapeutic process to expect:

- Each patient's treatment is individually designed.
- The treatment plan starts with techniques to control pain. This may include home treatment techniques, such as ice, heat, massage or mobilization.
- The next goal is to increase the movement and strength, which will be easier when you are in less pain and which will help to continue to decrease pain.
- Prevention of reoccurrence and return to your daily activities and sports is the final phase.

You can best help us meet your goals by attending all of your prescribed appointments, arriving on time and doing your prescribed home exercise program. Please schedule all of your appointments (normally 2 times for 6 weeks) at the time of your first visit in order to secure your best available time with your Physical Therapist.

There is a tendency for patients to drop out of physical therapy when the pain is under control. This is human nature; but what we find is that if you stop at that point, you never fully deal with the underlying causes of your condition, which often results in a return of your condition. I recommend you speak with your physical therapist and/or our patient representatives Yamilette or Tiffany - in order to handle anything that might contribute to your dropping out and not fully resolving your problem. We also recommend that you schedule an appointment to try our post rehab Wellness & Fitness Program. (Discuss this when you are getting ready for discharge to see if it would be appropriate for you.)

Please let us know how you are progressing by filling out a success story form each time you have a win in your therapy. These stories are also forwarded to your doctor and can be used (with your permission) to encourage other patients who can't see the light at the end of the tunnel.

Sincerely,

Ann Duffy M.A., P.T
Owner

Duffy & Bracken

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Medical History Intake Form

Name _____ Date of Birth _____ Age _____

Referred by: _____

Height _____ Weight _____ (*therapist calculate BMI*) _____

Are you currently under the care of an internist or family doctor or cardiologist? (*circle*)

Name and Phone Number _____

Circle any of the following, which you have had or have at present:

Heart Failure, Disease or Attack	Diabetes or Impaired Glucose	Cough
High Blood Pressure	Emphysema	HIV/AIDS
Fainting or Dizzy Spells	Kidney Disease	Sickle Cell Disease
Heart Surgery	Bladder Trouble	Psychiatric Treatment
Angina/Chest Pain	Liver Disease	Artificial Joint
Heart Pacemaker	Asthma	Rheumatism
Artificial Heart Valve	Emphysema	Ulcers
Swollen Ankles	Cancer or Tumor	Tuberculosis
Stroke	Chemotherapy	Syphilis
Heart Murmur	Radiation Treatment	Gonorrhea

Do you have a family history of cardiovascular disease (*Sudden death due to Cardiovascular event before age 55 in male immediate family or before age 65 in female immediate family*)?

Are you taking medication for high cholesterol or hypertension? Has a doctor ever told you that you have high cholesterol? _____

Are you currently on medications now?

List _____

Have you taken any medications or drugs during the past two years for other conditions?

List medication and condition _____

Do you smoke cigarettes? Y N How often? _____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? _____

Are you on a special diet? _____

Do you exercise regularly? (*specify*) _____

Do you have any disease, condition or problem not listed here? (*specify*) (*include past surgeries*)

WOMEN: Are you pregnant?	YES	NO
Are you practicing birth control?	YES	NO
Do you anticipate becoming pregnant?	YES	NO

To the best of my knowledge, all of the above answers are true and correct. If I ever have any changes in my health, or if my medications change, I will inform my treating physical therapist at the next appointment.

Signature of Physical Therapist _____ Date _____

Signature of Patient, Parent or Guardian _____ Date _____

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QUESTIONNAIRE FOR URINARY BOWEL CONTROL AND PELVIC FLOOR PAIN

(Check all that apply)

Medical History

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Herpes
<input type="checkbox"/> Lung/breathing problems/asthma	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Food allergies	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> HPV
<input type="checkbox"/> Medication Allergies	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other virus
<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> Leg pain	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Pelvic pain
<input type="checkbox"/> Low back pain	<input type="checkbox"/> GI dysfunction	<input type="checkbox"/> Do you smoke?
<input type="checkbox"/> Are you pregnant?	<input type="checkbox"/> Depression	<input type="checkbox"/> Other medical history/injuries:
<input type="checkbox"/> Have you been in major accidents or falls?	<input type="checkbox"/> Are you being treated with medication therapy?	_____

Gynecological History

Number of pregnancies		
Number of vaginal deliveries		
Dates of vaginal deliveries		
Length of pushing		
Did you tear?	Y	N
Number of episiotomies		
Do you have a painful episiotomy scar?	Y	N
Number of C-sections		
Do you have a history of urinary track infections?	Y	N
When was your Menopause onset?		
Do you have a history of urine loss as a child?	Y	N
Do you have a history of urine loss as an adult?	Y	N
Do you have a history of urine loss after child birth?	Y	N
Do you use a diaphragm?	Y	N
Do you use tampons?	Y	N

Surgical History

<input type="checkbox"/> Back/neck surgery	<input type="checkbox"/> Gall bladder surgery	<input type="checkbox"/> Hysterectomy (abdom)
<input type="checkbox"/> Kidney surgery	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hysterectomy (vaginal)
<input type="checkbox"/> Bladder repair	<input type="checkbox"/> Hernia	<input type="checkbox"/> Ovaries removed
<input type="checkbox"/> Other surgeries:		

Current Pain

Do you have pain with:		
<input type="checkbox"/> Intercourse	<input type="checkbox"/> Ovulation (mid cycle)	<input type="checkbox"/> Contact with clothing
o Initial penetration	<input type="checkbox"/> Just before period	<input type="checkbox"/> Abdominal pain
o Deep penetration	<input type="checkbox"/> During period	<input type="checkbox"/> Sitting
o Erection	<input type="checkbox"/> After period	<input type="checkbox"/> Walking
o Ejaculation	<input type="checkbox"/> Full bladder	<input type="checkbox"/> Sleeping
o Orgasm	<input type="checkbox"/> While voiding	<input type="checkbox"/> Standing
o Arousal	<input type="checkbox"/> After voiding	<input type="checkbox"/> Other (explain)
<input type="checkbox"/> After intercourse	<input type="checkbox"/> Bowel movement	_____

Where is your pain currently? _____
What do you think is causing your pain? _____
Is there an event that you associate with onset of your pain? _____
If so, what? _____

Current Medication (*prescription, non-prescription*)

Have you been on Hormone Replacement Therapy?	Y	N
Dosage: <input type="checkbox"/> Estrogen	Type: <input type="checkbox"/> Pills	
<input type="checkbox"/> Progesterone	<input type="checkbox"/> Patch/ring	
	<input type="checkbox"/> Cream	

Bladder

Do you:		
Experience an urge to urinate when you hear running water or as you enter your home and are you then unable to get to the toilet?	Y	N
Have difficulty initiating a urine stream?	Y	N
Have difficulty stopping your stream?	Y	N
Have pain with urination?	Y	N
Have burning with urination?	Y	N
Have blood in your urine?	Y	N
Have to strain to empty your bladder?	Y	N
Dribble urine while you are urinating?	Y	N
Dribble after you empty your bladder?	Y	N
Have a "falling out" feeling?	Y	N

Voiding Patterns

Voiding Frequency:	# of times/day	# of times/night
Incontinence:	# of episodes/day	# of episodes/night
Amount of urine lost: (<i>Check all that apply</i>)	Large <input type="checkbox"/> Small <input type="checkbox"/>	Few drops <input type="checkbox"/>
	Wet underwear <input type="checkbox"/> Wet outer clothes <input type="checkbox"/>	Wet floor <input type="checkbox"/>

Urine loss caused by:	<i>Always</i>	<i>Sometimes</i>	<i>Never</i>
Laugh			
Cough			
Sneeze			
Walking			
Running			
Lifting			
Anxiety			
Urgency			
Intercourse			
Other: _____			

Daily Fluid Intake

How many cups of non-caffeinated/non-carbonated fluid are you drinking daily?
How many cups of coffee_____, caffeinated tea_____, soda_____, alcoholic beverages____ are you drinking daily?
Do you restrict fluids because of your incontinence?

Protective Devices

What type of protective devices do you use? (check all that apply)		
<input type="checkbox"/> Panty liner		
<input type="checkbox"/> Sanitary pad (mini)		
<input type="checkbox"/> Sanitary pad (maxi)		
<input type="checkbox"/> Incontinence pad (poise <input type="checkbox"/> attends <input type="checkbox"/> serenity <input type="checkbox"/>)		
<input type="checkbox"/> Incontinence brief		
How many pads do you use each day?		
Do you soak the pad fully?	Y	N

Previous Treatment for Incontinence

Have you done exercises to control urine loss (Kegels)?	Y	N
Has your doctor prescribed any medication to treat urine loss?	Y	N
Have you had any surgical procedures to treat urine loss?	Y	N

Bowel Habits

How often do you have a bowel movement?		
Are you ever constipated?	Y	N
How do you resolve constipation?		
Do you use laxatives?	Y	N
How often do you use laxatives?		
Do you use enemas?	Y	N
How often do you use enemas?		
Do you include fiber in your diet (fruit, veg, bran, etc.)?	Y	N
Do you experience diarrhea?	Y	N
Do you experience loss of feces unexpectedly?	Y	N

Mobility/Self-Care

Do you use a cane/walker?	Y	N
Do get regular exercise – please explain?	Y	N
Do you lean on furniture for balance?	Y	N
Do you have difficulty with getting on/off the toilet?	Y	N
Do you have difficulty getting clothes on/off?	Y	N
Do you have difficulty with toilet hygiene?	Y	N

Psychosocial Aspects

Do you live alone?	Y	N
What is your occupation?		
Do you do any recreational activities?	Y	N
What kind?		
Have you had to restrict your activities due to urinary incontinence?	Y	N
Do you empty your bladder frequently so that you stay dry?	Y	N
Have you had changes in intimate relationships/sexual functioning due to your symptoms?	Y	N

What are your feelings about your urinary incontinence on a scale of 1 to 10:

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

No impairment

Severe Impairment

What are your feelings about your pain on a scale of 1 to 10:

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

No pain

Worst Pain Imaginable

Are you sexually active now	Y	N
Do you have anal intercourse	Y	N
Have you experienced sexual or physical abuse in the past	Y	N
What are your rehabilitation goals/expectations?		

Signature: _____

Date: _____

Duffy & Bracken

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DATE: _____

Home Phone: (____) _____

Work Phone: (____) _____

Cell Phone: (____) _____

Email: _____

Emergency Contact: _____

Emergency Phone: _____

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP _____

EMPLOYER: _____

ADDRESS: _____

JOB TITLE/OCCUPATION: _____

BIRTHDATE: ____ / ____ / ____ AGE: _____

SOCIAL SECURITY: ____ - ____ - _____

MARITAL STATUS: _____ SEX: _____

HOW DID YOU HEAR ABOUT US? _____

Because physical therapy requires frequent patient visits and new patients referred for treatment need to be scheduled and treated as promptly as possible, tight scheduling procedure is required by this office in order to provide the best of care of all of our patients. When one does not show up for treatment, it is time taken away from others who could utilize that treatment time.

We advise you to consider the importance of attending your scheduled treatment. Please help us to give you and all of our patients the best service possible.

SIGNED: _____

Duffy & Bracken

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Patient Acknowledgement of Understanding of the Direct Access to Physical Therapy Regulations

As of November 23, 2006, people in New York who need physical therapy services can go directly to their physical therapist without having to wait for a prescription from a physician. This DIRECT ACCESS TO PHYSICAL THERAPY LEGISLATION allows physical therapists to treat a patient for 10 visits or for a period of 30 days (whatever comes first) before a prescription from a physician must be obtained to continue physical therapy. Exceptions are no-fault and workers compensation, which still require a prescription at the first visit.

This is to acknowledge that I understand the New York State Direct Access to Physical Therapy Law and will obtain a prescription from my physician (either a specialist or primary care physician) after 10 visits or within 30 days of the start of my treatment at Duffy & Bracken Physical Therapy P.C.

Printed Name of Patient

Signature of Patient

Date

Duffy & Bracken

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75 MAIDEN LANE - NEW YORK, NY 10038 - PHONE (212) 402-5430 – FAX (212) 402-5432

WWW.DUFFYANDBRACKEN.COM

NO-SHOW AND LATE CANCELLATION POLICY

Because physical therapy requires frequent patient visits and new patients referred for treatment need to be scheduled and treated as promptly as possible, a tight scheduling procedure is required by this office in order to provide the best care to all our patients. When one does not show up for treatment, or cancels the same day, it is time taken away from others who could utilize that treatment time.

Duffy & Bracken charges a \$75.00 no-show/late cancellation fee. We define a NO-SHOW as a patient who does not appear for a scheduled appointment; we define a LATE CANCELLATION as a patient who does not give us a 24-hour notice of cancellation. **The fee is your responsibility and will not be paid by your insurance company. It must be paid in full before your next treatment can be given.**

We advise you to consider the importance of attending your scheduled treatment. Please help us to give you and all of our patients the best service possible.

PAYMENT RELEASE AUTHORIZATION

I request that payment of authorized health benefits be made either to me or on my behalf to Duffy & Bracken Physical Therapy PC for any services furnished to me by the physical therapist. I authorize any holder of medical information about me to release to a representative of Duffy & Bracken any information needed to determine these benefits or the benefits payable for related services.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have received and reviewed Duffy & Bracken Physical Therapy P.C. Notice of Privacy Practices. If I have any questions, I can contact the Practice at: 212-402-5430.

I HAVE READ AND UNDERSTAND THE TERMS OF THE ABOVE POLICIES AND NOTICES:

Signed: _____ Date _____