CORNERSTONE
PHYSICAL THERAPY, INC.
& WELLNESS

The Overlook at Lake Julian
600 Julian Lane, Suite 660, Arden, NC 28704

1201 Bleachery Blvd, Suite 201
Asheville, NC 28803

Newbridge Commons
218 Elkwood Ave, Suite 103, Asheville, NC 28804

cornerstoneptnc.com P 828-684-3611 F 828-684-3612 cpt@cornerstoneptnc.com

PATIENT REGISTRATION

Date_____ Patient Name_____ Birthdate_____

Social Security Number _____Marital Status_____ Sex_____

If Under 18: Guardian's Name_____ Birthdate_____

Address_____ City _____ State ___ Zip _____

Phone Number _____Cell_____

Email_____ Preferred Language_____

Race (optional)_____ Ethnicity (optional)___Hispanic ___Non-Hispanic

Employer_____Occupation_____

Employer's Address_____ Work Phone_____

Notify In Emergency_____Phone_____Relation_____

How did you hear about us?

Doctor:
_____

Dentist:
_____

Self Referral: (circle one) Workshop Social Media Google Company Website Race/Event

Other: _____

Friend/Family:
_____

Is this due to an automobile accident or a work-related injury? ____Yes ____No If yes, please provide a contact name (Adjuster, Case Manger), phone number, claim number, etc. in order for us to properly bill your claims:_____
_____

The information above is given to the best of my knowledge and represents my current information. Failure to supply correct information may result in the patient being responsible for services rendered.

_____ _____
Patient/Guardian Signature **Witness Signature**

_____ _____
Print Name **Print Name**

CANCELLATION POLICY

If you need to change or cancel your appointment for any reason, we **request at least 48 hours' notice. Failure to call by 12 pm on the day prior to your appointment may result in a $50.00 fee not covered by insurance**. This fee will be due in full at your next treatment session. This advanced notice allows us to fill your slot with another patient in need of treatment. Repeated changes with or without notice, multiple cancellations, will result in restricting your ability to schedule future appointments.

I understand and agree to the terms stated above.

_____ _____

Patient/Guardian Signature **Witness Signature**

_____ _____

Print Name **Print Name**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Cornerstone Physical Therapy, Inc. to release all my (or my dependent's) records to: ***(Medicare & Medicaid patients must provide a primary care physician):***

City/State/Phone Number

Your family physician: _____

Other physician/provider: _____

Other physician/provider: _____

Family Members/Friends: _____

CONSENT TO TREAT:

_____ I authorize Cornerstone Physical Therapy, Inc. to administer all necessary treatments and care (initial) required for my (or my dependent's) rehabilitation.

HIPAA DISCLOSURE STATEMENT:

_____ I acknowledge that I have been informed of the Provider Notice of Practices which is located in (initial) the reception area of this facility.

PHONE CALL AUTHORIZATION:

I authorize Cornerstone Physical Therapy, Inc. to leave messages on my answering machine regarding relevant information. _____(Initial) _____(Decline)

I authorize Cornerstone Physical Therapy, Inc. to text message my cell phone for appointment reminders. I further understand that ***I cannot text message Cornerstone Physical Therapy, Inc. to cancel or reschedule my appointments, and that I must call the office to handle these matters.***

_____(Initial) _____(Decline)

I understand and agree to the all of the terms stated above.

_____ _____

Patient/Guardian Signature **Witness Signature**

_____ _____

Print Name **Print Name**

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Pelvic Floor Therapy Questionnaire

Name_____ Date of Birth_____

Sex/Gender _____ Preferred Pronoun _____

Referring MD_____Occupation_____

Reason for Referral_____

History

Please check that all apply

☐ High blood pressure
☐ Heart Disease
☐ Circulation Disease
☐ Thyroid Condition
☐ Diabetes
☐ Osteoporosis
☐ Arthritis
☐ Breathing problems
☐ Cancer
☐ Allergies

Height_____

Weight_____

Medications? _____

Surgeries?_____

Other (Please list any other medical problems):_____

Number of pregnancies_____ Number of vaginal deliveries_____

Birth Weight of largest baby_____ Number of cesarean deliveries_____

Number of episiotomies_____ Date of last pap smear_____

Yes	No	
☐	☐	Did you have any trouble healing after birth?
☐	☐	Do you have a history of sexual abuse or trauma? (optional)
☐	☐	Are you having regular periods/menstrual cycles?
☐	☐	Do you have frequent urinary tract infections?
☐	☐	Are you on hormone therapy?
☐	☐	Endometriosis?
☐	☐	Pelvic Inflammatory Disease?
☐	☐	Cysts?
☐	☐	Fibroids?
☐	☐	Prolapse?

Pain

Yes	No	
☐	☐	Do you have pain with sexual intercourse?
☐	☐	Do you have pain with pelvic exams?
☐	☐	Do you have pain with tampon use?
☐	☐	Do you have back, leg, groin or abdominal pain?

Bladder Symptoms

Do you lose urine when you:

Yes	No		Yes	No	
☐	☐	Cough/laugh/sneeze?	☐	☐	Lift/exercise/dance/jump?
☐	☐	On the way to the bathroom?	☐	☐	Have strong urge to urinate?
☐	☐	Hear running water?	☐	☐	Sexual activities?
		Other_____			
☐	☐	Do you wet the bed?	☐	☐	Feel unable to empty your bladder?
☐	☐	Have burning/pain with urination?	☐	☐	Have a falling out feeling?
☐	☐	Difficulty starting a stream of urine?	☐	☐	Have and urgency of urination?
☐	☐	Strain to empty your bladder?	☐	☐	Urinate more than 7 times a day?

Bowel Symptoms

Yes	No		Yes	No	
☐	☐	Strain to have a bowel movement?	☐	☐	Leak/stain feces
☐	☐	Include fiber in your diet?	☐	☐	Have diarrhea often?
☐	☐	Take laxative/enema regularly?	☐	☐	Leak gas by accident?
☐	☐	Have very strong urge to move your bowels?			

How often do you move your bowels: _____per day/per week

Most common stool consistency?

____liquid _____soft _____firm _____pellets _____other_____

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Pelvic Floor Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunction includes, 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: 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 perineal region including the vagina and/or rectum. This evaluation will assess skin conditions, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not 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 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 cooperate with and carry out the home 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 and discomfort or unusual symptoms during evaluation.
4. I have the option of having a second person present in the room during the procedure, that I will provide, and I _____choose_____decline this option.
5. I decline the option of internal exams_____

_____ _____

Patient Signature Witness Signature

_____ _____

Print Name Print Name