CORNERSTONE
PHYSICAL THERAPY, INC.
The Overlook at Lake Julian • 600 Julian Lane, Suite 660, Arden, NC 28704
phone: 828-684-3611 • fax: 828-684-3612 • web: www.cornerstoneptnc.com

PATIENT REGISTRATION

Date_____ Patient Name_____ Birthdate_____

Social Security Number _____Marital Status_____ Sex_____

If Under 18: Guardian's Name_____ Birthdate_____ SSN_____

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? (List all that apply)

Yelp Angie's List

Doctor: _____ Google Company Website

Dentist: _____ Friend/Family: _____

Other: _____

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 your appointment, we require at least **24 hours notice** or there will be a **$35.00 fee** not covered by insurance. This allows us to fill your slot for another patient in need of treatment. Rescheduling your appointment within the same calendar week (M-F) will allow us to waive the fee in some instances, but repeated changes without notice or two no-call, no-show visits will result in discharge from the practice.

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**

CORNERSTONE PHYSICAL THERAPY, INC.
The Overlook at Lake Julian • 600 Julian Lane, Suite 660, Arden, NC 28704
phone: 828-684-3611 • fax: 828-684-3612 • web: www.cornerstoneptnc.com

Pelvic Floor Therapy Questionnaire

Name_____ Date of Birth_____

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?_____

Any history of trauma?_____

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?
☐	☐	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 you bowels: _____per day/per week

Most common stool consistency?

____liquid _____soft _____firm _____pellets _____other_____