



**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)**

Doctor: \_\_\_\_\_  
 Dentist: \_\_\_\_\_ Friend/Family: \_\_\_\_\_  
 Other: \_\_\_\_\_

- Yelp
- Angie's List
- Google
- Company Website

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



## Pelvic Floor Therapy Questionnaire (Male)

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): \_\_\_\_\_

### Bladder Symptoms

Do you lose urine when you:

Yes No

- Cough/laugh/sneeze?
- On the way to the bathroom?
- Hear running water?

Other \_\_\_\_\_

- Do you wet the bed?
- Have burning/pain with urination?
- Difficulty starting a stream of urine?
- Strain to empty your bladder?

Yes No

- Lift/exercise/dance/jump?
- Have strong urge to urinate?
- Sexual activities?
- Feel unable to empty your bladder?
- Have a falling out feeling?
- Have and urgency of urination?
- Urinate more than 7 times a day?

**Bowel Symptoms**

Yes No

- Strain to have a bowel movement?
- Include fiber in your diet?
- Take laxative/enema regularly?
- Have very strong urge to move your bowels?

Yes No

- Leak/stain feces
- Have diarrhea often?
- Leak gas by accident?

How often do you move you bowels: \_\_\_\_\_per day/per week

Most common stool consistency?

\_\_\_\_liquid    \_\_\_\_soft    \_\_\_\_firm    \_\_\_\_pellets    \_\_\_\_other\_\_\_\_\_