



NEW PATIENT INFORMATION SHEET

HOW DID YOU HEAR ABOUT US? [] PHYSICIAN [] WEBSITE [] FACEBOOK
[] SEMINAR [] NEWSPAPER AD [] FRIEND [] RETURNING PATIENT [] OTHER

Name (First) (Middle) (Last) (Suffix)

Mailing Address

(City) (State) (ZIP)

Phone: Home Cell Work

Primary Phone Email Address

Date of Birth Age Marital Status: [] Married [] Divorced [] Single [] Other [] Unknown

[] Widowed [] Separated Gender: [] Male [] Female Social Security #

Driver License #

Employment Status: [] Full Time [] Part Time [] Not Employed [] Self-Employed [] Retired [] Active Military
[] Unknown [] Full Time Student

In case of emergency, please notify Phone

Attorney involvement? [] Yes [] No Attorney name Phone

Name of Employer, Parent or Guarantor

Street Address of Employer or Parent

City, State and ZIP of Employer or Parent

Name of Spouse Spouse Date of Birth

Spouse's Employer Phone

Have you received any therapy this year? [] Yes [] No

Have you been seen for nursing or physical therapy services in your home by a Home Health Agency prior to
requesting services through our organization? [] Yes [] No If yes, name of home health agency

Primary Care Provider/Family Doctor Phone

The two documents listed below are available for review at the Lake Centre for Rehab front office.

- 1. Authorization for Treatment, Assignment of Benefits, Payment Responsibility and Disclosure of ALF Resident
Information.
2. Acknowledgement of Receipt of Privacy Notice in combination with Voluntary Consent.

The listed individuals may have access to my PHI (Protected Health Information):

Patient/Representative Signature Date

Witness Date

Guardian Signature if patient is a minor Date

Relationship to Patient



Patient Name

Facility

**SCREENING FOR PREVIOUS PT/OT/ST SERVICES UNDER
MEDICARE PART B CAPS**

Effective January 1, 2019, therapy providers are required to assure that Medicare is not billed more than \$2,040 for physical and speech therapy services combined, and \$2,040 for occupational therapy services. Each provider is required to track the entire therapy episode regardless of setting.

1. Have you previously received Part B therapy services in a skilled nursing facility?
 Yes No If yes, by whom and how much? _____

2. Have you previously received Part B therapy services in a physician's office? Yes No
If yes, by whom and how much? _____

3. Have you previously received Part B therapy services in an outpatient clinic? Yes No
If yes, by whom and how much? _____

4. Have you previously received Part B therapy services in your home? Yes No
If yes, by whom and how much? _____

Signing below indicates that the answers above are true and correct, and that the information is complete to the best of the signor's knowledge.

Patient Signature

Witness Signature

Date

Date



MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient _____

Medicare # _____ Admit/Eval Date _____

Facility _____ Provider # _____

1. Is the patient covered by Veterans Administration or Black Lung? Yes No
2. Was illness due to an injury? Yes No If yes,
 - a. Date of accident _____
 - b. What type of accident cause your illness/injury? _____
 - c. Is the patient filing or intending to file a liability suite? _____
If yes, please give name and address of attorney _____
3. Is the patient employed (Medicare disabled beneficiaries under the age of 65 or Medicare over the age of 65) and covered by a group health plan? Yes No
 - a. Date of retirement _____
 - b. Is the patient married? _____
 - c. Is the spouse currently employed? _____
 - d. Does the spouse have group coverage? _____
 - e. Does the patient have coverage through a spouse, parent or guardian's employer group health plan? _____
4. Is the patient entitled to benefits solely on the basis of end stage renal disease? Yes No Has the patient been undergoing kidney dialysis for more than 12 months? Yes No

If you answered yes to any of the above questions, you will need to fill out the information requested below.

Insurance company _____

Address _____

Policy/certificate number _____

Group name _____

Group number _____

PATIENT SIGNATURE _____ DATE _____

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

Relationship to patient _____

Signature of person completing this form _____ Date _____
(If other than the patient)

Patient Name _____ Date _____

Female Pelvic Floor Questionnaire

Conditions related to the pelvic floor muscles can affect bladder, bowel, sexual, and physical function. Please answer the questions below so that we can better understand your problem. Please check all that apply.

History of Current Condition

Reason for today's visit _____

How long have you had this problem? _____

Since the problem began, has the problem become: Worse Better Unchanged

Is it related to an injury or accident? No Yes Explain how and when _____

What are your goals for treatment? _____

Previous Treatments for your condition:

<input type="checkbox"/> Kegel exercises	<input type="checkbox"/> Rectocele repair	<input type="checkbox"/> Tubal ligation	<input type="checkbox"/> Massage therapy
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Hemorrhoid repair	<input type="checkbox"/> Infertility treatments	<input type="checkbox"/> Chiropractor
<input type="checkbox"/> Pelvic floor rehab	<input type="checkbox"/> Radiation	<input type="checkbox"/> Removal of endometria	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Diet/fluid changes	<input type="checkbox"/> Ostomy pouch	<input type="checkbox"/> Removal of adhesions	<input type="checkbox"/> Vaginal dilators
<input type="checkbox"/> Pessary	<input type="checkbox"/> Hemorrhoid cream	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Over the counter pain meds
<input type="checkbox"/> Bladder surgery	<input type="checkbox"/> High fiber diet	<input type="checkbox"/> Abdominal	<input type="checkbox"/> Prescription pain meds
<input type="checkbox"/> Bladder control meds	<input type="checkbox"/> Probiotics	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Bladder instillations
<input type="checkbox"/> Collagen injections	<input type="checkbox"/> Stool softeners	<input type="checkbox"/> With bladder repair	<input type="checkbox"/> Urethral/bladder dilation
<input type="checkbox"/> InterStim	<input type="checkbox"/> Constipation meds	<input type="checkbox"/> One ovary removed	<input type="checkbox"/> Nerve injections/blocks
<input type="checkbox"/> Self-catheterization	<input type="checkbox"/> Anti-diarrheal meds	<input type="checkbox"/> Both ovaries removed	<input type="checkbox"/> Other _____
<input type="checkbox"/> BCG	<input type="checkbox"/> Herbal supplements	Reason _____	
	<input type="checkbox"/> Enemas	Age _____	

Have you received therapy for the current or other problem in the past year? Yes No If yes, indicate type (physical therapy, speech therapy, etc.) and date _____

Previous Tests for your condition:

<input type="checkbox"/> Urodynamics study	<input type="checkbox"/> Video defacography	<input type="checkbox"/> X-ray	<input type="checkbox"/> Hysteroscopy
<input type="checkbox"/> Bladder scan (PVR)	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> CT scan	<input type="checkbox"/> Potassium test
<input type="checkbox"/> Cystoscopy	<input type="checkbox"/> Anal manometry	<input type="checkbox"/> MRI	<input type="checkbox"/> Exploratory surgery

Medical Conditions and Health Status

Please rate your overall health: Excellent Good Fair Poor

With whom do you live? Alone Spouse/significant other Other relative(s) Roommate(s)

Where do you live? Private home or apartment Independent living Assisted living Other _____

Bladder	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Small bladder capacity	<input type="checkbox"/> Bladder cancer	<input type="checkbox"/> Bladder infections (UTI's)
	<input type="checkbox"/> Overactive bladder	<input type="checkbox"/> Large bladder capacity	<input type="checkbox"/> Interstitial cystitis	<input type="checkbox"/> Painful bladder syndrome
	<input type="checkbox"/> Urinary retention	<input type="checkbox"/> Fallen bladder (cystocele)	<input type="checkbox"/> Other _____	
Bowels	<input type="checkbox"/> Fecal incontinence	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Colon cancer
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Spastic colon	<input type="checkbox"/> Lactose intolerance	<input type="checkbox"/> Anal cancer
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Gluten intolerance	<input type="checkbox"/> Colostomy/ileostomy
	<input type="checkbox"/> Irritable bowel synd.	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Other _____	
Obstetrical	_____ Number of pregnancies		<input type="checkbox"/> Vaginal tear	
	_____ Number of vaginal deliveries		<input type="checkbox"/> Episiotomy	
	_____ Number of C-Section deliveries		<input type="checkbox"/> Vaginal stitches	
	_____ Weight of largest baby		<input type="checkbox"/> Use of forceps or suction	
	I'm pregnant now; due date _____		<input type="checkbox"/> Other complications _____	

Patient signature _____

Patient Name _____ Date _____

Gynecological	<input type="checkbox"/> Endometriosis <input type="checkbox"/> Vulvodynia <input type="checkbox"/> Vaginismus <input type="checkbox"/> Pudendal neuralgia <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Uterine cancer <input type="checkbox"/> Yeast infections	<input type="checkbox"/> Ovarian cysts <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Uterine prolapse <input type="checkbox"/> Bladder (cystocele) <input type="checkbox"/> Rectum (rectocele) <input type="checkbox"/> "Falling out" feeling <input type="checkbox"/> Bulge in the vagina <input type="checkbox"/> Other _____	<u>Menstruation Status</u> <input type="checkbox"/> Normal periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Peri-menopausal <input type="checkbox"/> Post-menopausal <input type="checkbox"/> Hysterectomy	<u>Use of Hormones</u> <input type="checkbox"/> None used <input type="checkbox"/> Birth control pills <input type="checkbox"/> Estrogen replacement <input type="checkbox"/> Oral medication <input type="checkbox"/> Skin patch <input type="checkbox"/> Vaginal cream <input type="checkbox"/> Suppository																											
	<u>Sexual Function:</u> <input type="checkbox"/> I'm sexually active <input type="checkbox"/> I'm not sexually active due to: <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;"><input type="checkbox"/> My pelvic pain symptoms</td> <td style="width:50%; border:none;"><input type="checkbox"/> My other medical problems</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> For non-health related reasons</td> <td style="border:none;"><input type="checkbox"/> My partner's medical problems</td> </tr> </table>				<input type="checkbox"/> My pelvic pain symptoms	<input type="checkbox"/> My other medical problems	<input type="checkbox"/> For non-health related reasons	<input type="checkbox"/> My partner's medical problems																							
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Other Medical	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart disease <input type="checkbox"/> Heart attack <input type="checkbox"/> Angina <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Cardiac arrhythmia <input type="checkbox"/> Pacemaker/defibrillator <input type="checkbox"/> Vascular disease <input type="checkbox"/> Swollen legs/edema <input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchitis	<input type="checkbox"/> Asthma <input type="checkbox"/> Cigarette smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Stroke <input type="checkbox"/> TIA (mini strokes) <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Seizures <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones <input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Diabetes <input type="checkbox"/> Acid reflux <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing loss <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Low back pain <input type="checkbox"/> Tailbone trauma	<input type="checkbox"/> Sciatica <input type="checkbox"/> Stenosis <input type="checkbox"/> Arthritis Area _____ <input type="checkbox"/> Herniated disc Level _____ <input type="checkbox"/> Degenerative disc Area _____ <input type="checkbox"/> Bone fracture Area _____ <input type="checkbox"/> Cancer Area _____ <input type="checkbox"/> Other _____																											
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Surgeries</th> <th style="width:15%;">Age or Year</th> <th style="width:33%;">Medications</th> <th style="width:19%;">For what condition?</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Surgeries	Age or Year	Medications	For what condition?																							
Surgeries	Age or Year	Medications	For what condition?																												
Allergies <input type="checkbox"/> None <input type="checkbox"/> Latex sensitivity <input type="checkbox"/> Seasonal (pollen/hay fever) <input type="checkbox"/> Bees <input type="checkbox"/> Other _____ <input type="checkbox"/> Food _____ <input type="checkbox"/> Medications _____																															
Review of Systems - Please check if you have you recently had any of these symptoms.																															
<input type="checkbox"/> Fever/chills <input type="checkbox"/> Weight change <input type="checkbox"/> Fatigue/night sweats <input type="checkbox"/> Skin rash/itch <input type="checkbox"/> Headaches <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Ear pain/discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Light sensitive	<input type="checkbox"/> Eye pain/redness <input type="checkbox"/> Chest pain <input type="checkbox"/> Pounding heart <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Calf pain <input type="checkbox"/> Leg swelling <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Phlegm production <input type="checkbox"/> Congestion <input type="checkbox"/> Wheezing <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Stomach pain <input type="checkbox"/> Bloody stools <input type="checkbox"/> Tarry stools <input type="checkbox"/> Blood in urine <input type="checkbox"/> Muscle pain <input type="checkbox"/> Neck/back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Falls <input type="checkbox"/> Arm/leg weakness <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Difficulty standing up <input type="checkbox"/> Tingling/numbness	<input type="checkbox"/> Tremors <input type="checkbox"/> Speech changes <input type="checkbox"/> Seizures <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Vertigo/spinning <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Lightheaded <input type="checkbox"/> Depression <input type="checkbox"/> Nervous/anxious <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Hallucinations <input type="checkbox"/> Substance abuse <input type="checkbox"/> Memory loss																												
Is your doctor aware of these recent symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No																															

Patient signature _____

Patient Name _____ Date _____

Please answer the questions below. If your symptom severity fluctuates, characterize your symptoms at their worst.

Bladder Health Do you have a urologist? Yes No If yes, who? _____

- During the **daytime**, how often do urinate? Every 30-60 minutes 1-2 hours 2-3 hours 3-4 hours
 More than 4 hours
- During the **nighttime** (after you've fallen asleep), how often do you get up to urinate? 0-1 times per night 2-3 times
 3-4 times More than 4 times
- How many **8 ounce servings** (cups) do you drink of the following?

Liquid	Per Day	Per Week	On Occasion	Never	Liquid	Per Day	Per Week	On Occasion	Never
Coffee (<input type="checkbox"/> Reg. <input type="checkbox"/> Decaf)					Water				
Tea (<input type="checkbox"/> Reg. <input type="checkbox"/> Decaf)					Milk				
Soda (<input type="checkbox"/> Reg. <input type="checkbox"/> Decaf)					Juice				
Beer/Wine/Liquor					Other _____				

- Do you **every lose urine (even a few drops)** with any of the situations below?

	Never	On Occasion	Sometimes	Usually	Always
Cough					
Sneeze					
Laugh					
Getting out of a chair					
Getting out of a car					
Getting out of bed at night					
Getting out of bed in the morning					
Picking objects off the floor					
Putting on shoes or clothes					
Lifting light items					
Lifting heavy items					
Cooking or doing dishes					
Doing housework					
Doing yard work					
During sexual activity					
Walking to the toilet at home					
Shopping or running errands					
Standing or walking for a long time					
Walking to toilet in public					
Recreational activities					
Exercise activities					
Other _____					

- Do you ever have **strong or difficult-to-control urges** to urinate with the situations listed below?

	Never	On occasion	Sometimes	Usually	Always
Around running water					
Feeling cold					
Feeling anxious or nervous					
Unlocking the door					
If I've waited too long					
Rushing off to the toilet					

Patient signature _____

Patient Name _____ Date _____

6. How long can you **usually delay an urge** to urinate? I rarely feel urges to void I go as soon as I feel an urge
 1-2 minutes Several minutes 10-15 minutes 15 minutes or more
7. What **type of protective padding** do you use for bladder control? None needed Change underwear
 Folded tissue paper Liners Thin pads Thick pads Diapers Other _____
8. How often do you **change your bladder protection**? None Only when I leave the house Only at night
 Only during a cold Only during exercise 1-2 per day 3-4 per day 4+ per day
9. How **saturated** does your protection get? No leakage "Near misses" A few drops Damp Wet Soaked
 Overflows onto clothes
10. How often do you go to the bathroom **before you feel urges** to void, "just in case?" Never On occasion Sometimes
 Usually Always
11. How often do you **avoid drinking** fluid in order to help with bladder control? Never On occasion Sometimes
 Usually Always
12. Do you ever notice any of the following **bladder symptoms**? Please check how often.

	Never	On occasion	Sometimes	Usually	Always
Weak stream					
Incomplete bladder emptying					
Trouble starting urine stream					
Strain to urinate					
Dribble after urinating					
Have to rock pelvis to empty bladder					
Have to push over the bladder to empty					
Splint or support bladder to urinate					
Pain as my bladder <i>fills</i>					
Location:	<input type="checkbox"/> Bladder <input type="checkbox"/> Urethra <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bladder <i>empties</i>					
Location:	<input type="checkbox"/> Bladder <input type="checkbox"/> Urethra <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

Bowel Health Do you have a gastroenterologist? Yes No If yes, who? _____

1. **How often** do you have a bowel movement? Less than 3 times a week Every 2-3 days Every 1-2 days Daily
 2-3 times per day More than 3 times per day I won't go for several days, and then go multiple times in one day
2. What is the **consistency** of your bowel movements? Watery/formless Loose and thin Soft and formed
 Hard and rocky Small and pellet-like It varies _____
3. Do you ever **lose feces** with any of the situations below? Please check how often.

	Never	On Occasion	Sometimes	Usually	Always
On the way to the toilet					
If I exert myself					
When I pass gas					
I have fecal soiling without an urge to have a BM					

4. What **type of protective padding** do you use for bowel control? None needed Change underwear
 Folded tissue paper Liners Thin pads Thick pads Diapers Other _____
5. How often do you **change your bowel protection**? None Only when I leave the house Only when I have diarrhea/
loose stools 1-2 per day 3-4 per day 4+ per day

Patient signature _____

Patient Name _____ Date _____

6. Do you every notice any of the following **bowel symptoms**? Please check how often.

	Never	On occasion	Sometimes	Usually	Always
Excessive straining during a BM					
Support/splint rectum during BM					
Incomplete BM's					
Rush to the toilet with BM urge					
Trouble controlling gas in public					
Excessive wiping needed after BM					
Fecal soiling in underwear after BM					
Pain as my bowels <i>fill</i>					
Location:	<input type="checkbox"/> Rectum <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bowels <i>empty</i>					
Location:	<input type="checkbox"/> Rectum <input type="checkbox"/> Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

GYN Health

Do you have an OB/GYN? Yes No If yes, who? _____

Vulvar symptoms: Dryness Itching Discharge Numbness/tingling Redness Swelling

Pelvic pain symptoms: None
 My pelvic symptoms **affect my ability** to, OR **I feel worse when I try** to: Check all that apply.

<input type="checkbox"/> Sleep	<input type="checkbox"/> Do yard work	<input type="checkbox"/> Get out of acar	<input type="checkbox"/> Perform work duties
<input type="checkbox"/> Bathe	<input type="checkbox"/> Bend forward	<input type="checkbox"/> Climb stairs	<input type="checkbox"/> Recreational activities
<input type="checkbox"/> Get dressed	<input type="checkbox"/> Squat down	<input type="checkbox"/> Sitting tolerance	<input type="checkbox"/> Social events
<input type="checkbox"/> Wear tight clothing	<input type="checkbox"/> Lift items	<input type="checkbox"/> Standing tolerance	<input type="checkbox"/> Travel
<input type="checkbox"/> Wear a tampon	<input type="checkbox"/> Reach overhead	<input type="checkbox"/> Walking distance	<input type="checkbox"/> Exercise for health
<input type="checkbox"/> Cook meals	<input type="checkbox"/> Get out of bed	<input type="checkbox"/> Drive a car	<input type="checkbox"/> Have a GYN exam
<input type="checkbox"/> Do housework	<input type="checkbox"/> Stand up from a chair	<input type="checkbox"/> Run errands/shop	<input type="checkbox"/> Do Kegel exercises

Pain Location: Check all that apply.

- | | | | | |
|--|---------------------------------------|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Inner thighs | <input type="checkbox"/> Side/waist | <input type="checkbox"/> Over tight surgical scars | <input type="checkbox"/> Vagina |
| <input type="checkbox"/> Clitoris | <input type="checkbox"/> Urethra | <input type="checkbox"/> Bladder | <input type="checkbox"/> Tailbone | <input type="checkbox"/> Rectum |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Buttocks | <input type="checkbox"/> Groin | <input type="checkbox"/> Sides of hips | <input type="checkbox"/> Back of hips |
| <input type="checkbox"/> Front of hips | | | | |

Circle pain severity: No Pain 0 1 2 3 4 5 6 7 9 10 Worst Pain

Pain with sexual activity:

- None I have to *interrupt* intercourse due to pain.
 I limit the *frequency* of sexual activity because of my pain. I *avoid it* altogether due to my pain. Last intercourse attempt: _____

The pain occurs during: Vulvar touching Vaginal penetration Thrusting Orgasm
 For how long? Only during sexual activity For a few hours afterwards For a day or more afterwards
 Location: Vaginal opening Clitoris Deep in my pelvis In my back
 Circle pain severity: No pain 0 1 2 3 4 5 6 7 9 10 Worst Pain

Patient signature _____



INSTRUCTIONS

**Before your first visit, download the patient forms from our website
www.golcr.com/forms**

On your first visit, please remember to bring the following:

1. Physician or NPP (Non-Physician Provider) order for therapy.
2. *Bring the patient forms you filled out*
3. Insurance cards (primary and secondary).
4. Photo ID.
5. Current list of medicines and allergies.
6. Recent reports that you might have, including x-rays, MRI's, surgeries, etc.
7. Loose-fitting, comfortable clothing.
8. Supportive closed-toe shoes.
9. Bring in any adaptive devices currently used, such as braces, canes, walkers, etc.
10. Copy of home health discharge with name and phone number of home health agency if applicable.
11. Notify us of implants and pacemakers (defibrillators).

**Due to allergies of staff members and
patients, please refrain from
strong fragrances.**