Welcome to Provenance Rehabilitation!

Thank you for entrusting us with your physical therapy needs. One of our main priorities is to provide a setting that is comfortable to you. Our goal for your first visit is for you to leave with a sense of hope and optimism about your condition and the plan of care that we establish with you.

The owner of Provenance Rehabilitation, Jennifer B. Hunt (Jenny), began her physical therapy career in 1993 working in various orthopedic settings before pursuing advanced training in pelvic floor rehabilitation in 2001. She directed a large women's health physical therapy program in Alpharetta for several years prior to opening her own practice in June 2010. Jenny's number one priority is providing the highest quality of care to all of her patients. In addition to her clinical work, she enjoys her role as a guest lecturer to physical therapy students about women's health and pelvic floor dysfunction. Jenny's educational background includes a Bachelor's degree in Biology from Rhodes College, a bachelor's degree in Physical Therapy from the University of TN, Memphis, and a Doctorate of Physical Therapy from Arcadia University.

What makes Provenance Rehabilitation unique?

- All patients receiving treatment at Provenance Rehabilitation have some form of pelvic pain and/or dysfunction (incontinence, organ prolapse, painful intercourse, or pregnancy-related conditions).
- We are in a medical building that has 7 different OB/GYN practices. Our office is located within one of these OB/GYN practices, and this setting allows for ease of collaboration with other health care professionals (physicians, midwives, nurse practitioners, and ultrasound technicians).
- Our patients are referred from health care providers from all over Georgia, the Mayo Clinic in Florida, and from specialists in other states. We also have a large percentage of patients who refer themselves after finding us on the internet.
- Each patient is seen for an hour. Treatment always combines education about the condition, manual therapy, exercises, and home program instruction.
- One patient is seen at a time in a private room rather than an open setting. Our facility has a strong focus is on patient privacy and professionalism.
- We have a Facebook page where Jenny occasionally posts articles about pelvic floor conditions and patient stories that are relevant to her practice.

Patient's Name: _____ Date of Birth:_____

Address:_____

Phone:_____Email Address:_____

Emergency Contact:_____Phone:_____

Referred by:_____Phone:_____

Other providers involved in the condition:

_____Phone:_____

_____Phone:_____

_____Phone:_____

Brief Description of Condition or Diagnosis:_____

_____

The fees have been discussed with me, and I understand that I am to pay for physical therapy services provided at the conclusion of each visit unless other arrangements have been agreed upon. I understand that it is my responsibility to find out about my insurance policy's out-of-network reimbursement for PT services. I will be provided a superbill that includes all necessary information for me to send to my insurance company for potential reimbursement.

_____

Patient's printed name Date

_____

Patient's signature Date

MEDICAL INTAKE FORM

Name: _____ Date of Birth: _____ Age: _____

Occupation: _____ Number of Work Hours/Week: _____

Do you smoke? Yes or No ___packs/day Alcohol use? Yes or No ____drinks/week

Marital Status: Married Divorced Single Other: _____

Hobbies/Leisure Activities: _____

Please describe any exercises you perform regularly (consistently 2 or more times/week): _____

_____

Please circle the following whose care you are currently under:

Family Physician	Naturopath	OB/GYN	Midwife
Cardiologist	Chiropractor	Psychiatrist	Endocrinologist
Psychologist	Neurologist	Osteopath	Sex Therapist
Cardiologist	Physical Therapist	Dentist	Other: _____

Please <u>briefly</u> explain what brings you to Physical Therapy today:

_____

_____

General Medical/Surgical History

Please circle any of the following conditions that you have ever experienced:

Heart Condition	Cancer (type): _____	
High Blood Pressure	IBS	High Cholesterol
Constipation	Chronic Diarrhea	Cyclic Vomiting Syndrome
Diabetes: Type 1 Type 2	Anxiety	Depression
Asthma	Stroke or TIA	Tremors
Chronic Cough	Blood Clot or PE	Seizures
Seasonal Allergies	Osteoporosis	Skin Disorder
Interstitial Cystitis	Fibromyalgia	Fatigue
Eating Disorder	Thyroid Problems: hypo or hyper	
Unintentional Weight Loss	Sleep Disorders	Liver Disease
Alcoholism	Drug Addiction	Kidney Disease

Osteoarthritis: Joints affected: _____

Rheumatoid Arthritis: Joints affected: _____

Please list any over-the-counter or prescription medications (including any type of hormone replacement therapy) you are using currently, including dosage and frequency.

_____

Please circle if you have had any the following surgeries/procedures:

D&C	Supracervical Hysterectomy
Total Hysterectomy	Oophorectomy L or R or both
Salpingectomy L or R or both	Sacral Colpopexy
Bladder Suspension	Appendectomy
Bowel Resection	C-Section

Prolapse Repair: Cystocele Rectocele Uterine Vaginal

Please provide dates and names of other medical procedures that you have had*:*

_____

Do you have a latex Allergy? Yes or No Allergy to Vaginal Lubricants? Yes or No
If you use a vaginal lubricant, what type do you use? _____
Please list any other allergies you may have: _____

Obstetrical History *if applicable*

Miscarriages: _____ # of weeks gestation: _____ # of Pregnancies carried full term: _____
Pre-term Deliveries: _____ # of weeks gestation: _____

Please circle the position(s) of labor:

lying on back with legs raised	on hands and knees	side-lying
squatting	standing-supported squat	in water
walking	Leaning or kneeling forward with support	

Other: _____

# of C-Sections: _____ Dates: _____
After-delivery Pain Rating (0-10): ___/10 Location of Pain: _____

Did you experience pain in the pelvic region when standing or walking **after** delivery?
Yes or No If yes, please describe:_____
Did you require assistance with walking after delivery due to pain? Yes or No
Did you breast feed? Yes or No Are you currently breast-feeding? Yes or No

Please circle any complications that you experienced <u>during pregnancy or after delivery</u>:

Gestational Diabetes	Back/Neck Pain	Fall/accident
Depression	Sciatica	Pubic Symphysis Pain
Carpal Tunnel Syndrome	Bed Rest	Diastasis Recti
Vaginal Tear	Vacuum Delivery	Forceps Delivery
Episiotomy: Midline or Mediolateral	Urinary Incontinence	Fecal Incontinence
Coccyx Fracture	Mastitis	Other: _____

Please circle degree of vaginal tear if known: No tear 1st 2nd 3rd 4th

Pelvic Health History

Please circle if you have experienced any of these conditions in the past or presently:

Leaking of Urine or Feces	Activities with leaking: _____	
Urinary Urgency	Urinary Frequency (OAB)	Painful Urination
Urinary Hesitancy	Weak Urine Flow	Blood in Urine
Night-Time Voiding: Yes or No	If yes, # of times/night? _____	
Difficulty Emptying Bladder	Frequent UTIs	Straining with Urination
Bladder or Urethral Pain	Abdominal Bloating	Constipation
Irregular Periods	Recurring Yeast Infections	Pain during intercourse
Vaginal Fissure	Anal Fissure	Rectovaginal Fistula

Vaginal Burning or Itching **<u>without</u>** infection

Bladder or Urethral Pain **<u>without</u>** urinary tract infection

Please circle if you have been diagnosed with Pelvic Organ Prolapse and degree (if known):

Bladder: 1st 2nd 3rd 4th Uterine: 1st 2nd 3rd 4th

Vagina: 1st 2nd 3rd 4th Rectum: 1st 2nd 3rd 4th

Do you experience a feeling of pressure/bulging in the perineum? Yes or No

If yes, does it worsen throughout the day and with increase in activity? Yes or No

Is the pressure/bulging sensation better first thing in the morning? Yes or No

What activities make the pressure/bulging worse? _____

Are you required to “splint" (use your fingers to press downward inside the vagina) in order to have a bowel movement? Yes or No

Reproductive Health and Function

Are you currently sexually active? Yes or No If no, have you ever been? Yes or No

What was the date of your last period? _____

Have you ever had a Pap Smear or pelvic exam? Yes or No

Date of last Pap Smear and/or pelvic exam: _____

Please circle which type of contraception you use currently:

None	Birth Control Pills	Intrauterine Device (IUD)	Estring
NuvaRing	Partner Vasectomy	Condoms	Other: _____

Please circle if you have ever experienced any of the following:

Low or absent libido	Pain during or after intercourse
Incontinence during intercourse	Inability to insert tampons into the vagina
Sexual abuse	

_____ _____
Patient Name (printed) Date

_____ _____
Patient Signature Parent Signature (if the patient is a minor)

Consent for Examination

In order for the physical therapist to complete a thorough examination, it may be necessary for an internal assessment to take place. This may require palpation of the pelvic floor muscles vaginally or rectally. If this type of examination is needed, the physical therapist will explain what will take place and ask for the patient's consent. If the patient is not comfortable with an internal assessment for any reason, this needs to be verbalized by the patient to the therapist. No type of internal assessment will take place without verbal and written consent of the patient.

By signing this paper, you are providing written consent to an internal assessment of the pelvic floor muscles if it is deemed necessary for your condition.

_____

Patient's printed name

_____ _____

Patient's signature Date

Cancellation & No Show Policy:

We strive to schedule all appointments as efficiently as possible in order to have adequate time with each of our patients. We request that you notify our office immediately once you realize you will not be able to keep your appointment or if you may be late for any reason.

If you need to cancel or reschedule your appointment, please do so at least **24 hours before your scheduled office visit to avoid paying a $75.00 fee**. This notice of 24 hours is important to allow scheduling of any other patients who are waiting to be seen.

Thank you for your attention to this matter.

_____

Patient's printed name

_____ _____

Patient's signature Date

Directions to our Facility

Driving north on GA 400:

- Take Old Milton Pkwy (exit 10), and get into the middle lane on the exit ramp. Turn right at the end of the ramp onto Old Milton Pkwy (heading east).
- Turn left at the very first traffic light, Morris Rd.
- Take the first right into our parking lot @ 11975 Morris Rd – the North Crescent Medical Center.
- Our suite number is #310A

Driving south on GA 400:

- Take Old Milton Pkwy (exit 10), and turn left off of the ramp to cross back over 400.
- Head east on Old Milton Pkway to the first traffic light after you've crossed 400.
- Turn left at this traffic light onto Morris Rd.
- Turn right into our parking lot @ 11975 Morris Rd – the North Crescent Medical Center.
- Our suite number is #310A