Provenance
REHABILITATION
specialists in pelvic health & wellness

11975 Morris Road, Suite 310A
Alpharetta, GA 30005
(678) 819-8720, (678) 819-8721 (fax)

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.

We look forward to having you as a client.

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).
- Our therapists are thoroughly trained with over 25 years of experience, capable of providing the service and care that you need.
- We treat both women and men who are experiencing pelvic-related issues.
- 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.
- 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 facilities have a strong focus on patient privacy and professionalism.
- We have a Facebook & Instagram page along with our website where we post articles about pelvic health conditions and patient stories (anonymous) that are relevant to our practice.

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Patient's Name: _____ DOB:_____Age:____

Address:_____

Phone:_____E-mail 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

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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, we ask that you please do so at least **24 hours before your scheduled office visit to avoid paying a $75.00 fee**.

We will ask you to provide a credit card number over the phone for us to use for collection of the cancellation fee if ever needed. Your credit card information will be stored safely in our electronic documentation system (not on paper).

Our policy is to charge the entire initial examination fee ($210) on the day of your reserved appointment if we are not given sufficient notification of cancellation or request to reschedule that appointment. Please understand that this policy is strictly enforced in our efforts to accommodate patients who are on a waiting list to receive our services.

We will always alert you before charging any fee to your card.

Thank you very much for your attention to this matter. Please sign below that you have read and understand our cancellation and no-show policy:

Patient's printed name _____

Patient's signature _____ Date _____

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Alpharetta - 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 at 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 the ramp to cross back over GA-400.
- Head east on Old Milton Pkway to the first traffic light after you have crossed GA-400.
- Turn left at this traffic light onto Morris Rd.
- Turn right into our parking lot at 11975 Morris Rd – the North Crescent Medical Center.
- Our suite number is #310A, 3rd floor.

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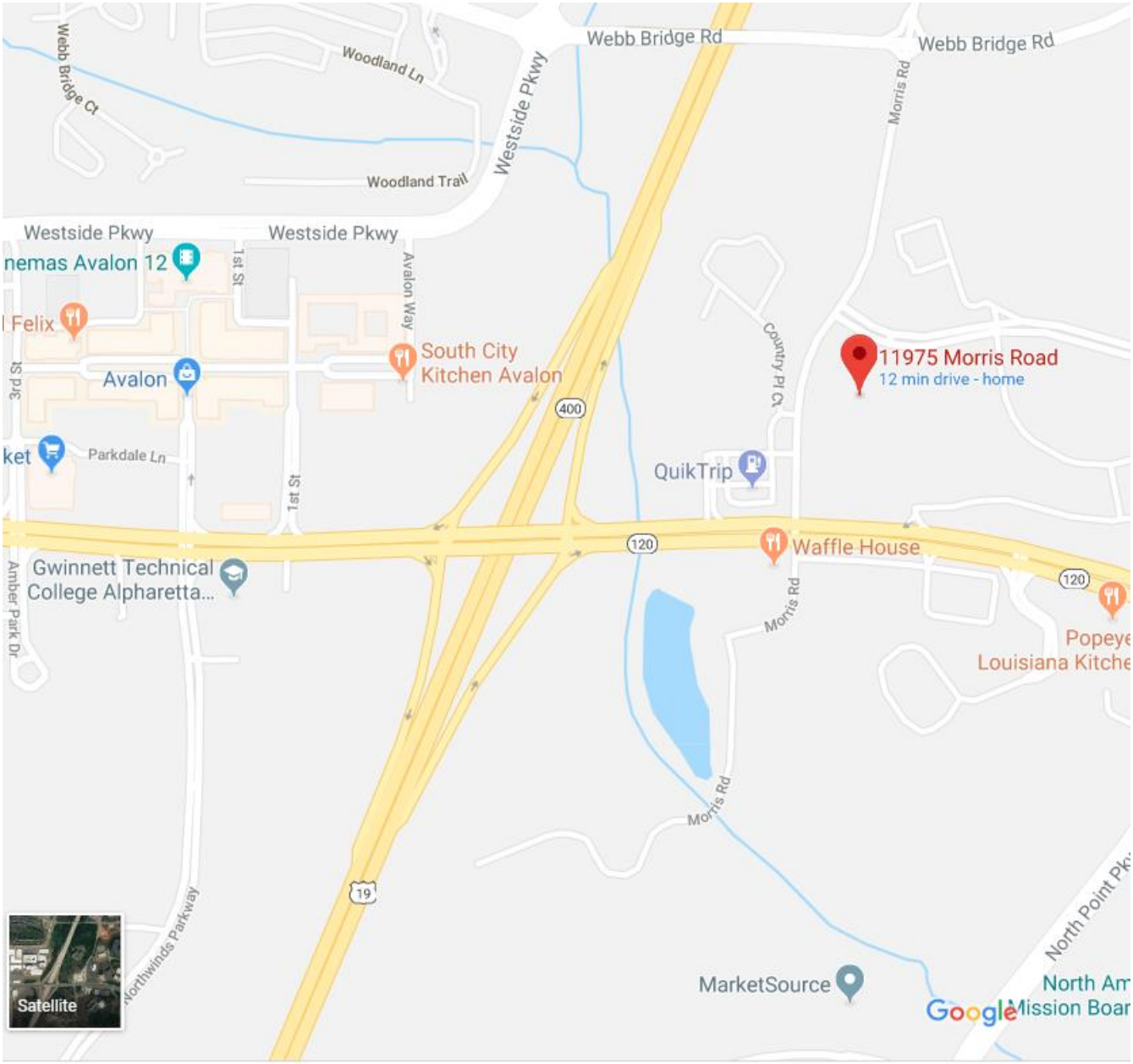

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Pelvic Intake Form

Patient Name: _____ Date:_____ DOB: _____

Age:_____ Weight: _____

Gender: Male Female

Occupation: _____ Relationship Status: _____

Hobbies / Leisure Activities:

_____

Exercise Routine:

_____

Briefly describe your current complaint:

_____

_____

When did this problem begin? _____ Is it getting better____ worse_____ same____

Rate your feelings as to the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10
0 = not a problem 10 = major problem

Do you now have or do you have a history of the following?

- ☐ Bladder infections
- ☐ Urinary frequency, hesitancy, urgency
- ☐ Pelvic pain
- ☐ Low back pain/sciatica
- ☐ Multiple Sclerosis
- ☐ Childhood bladder problems
- ☐ Trouble holding back gas
- ☐ Vaginal dryness
- ☐ Constant dribbling of urine
- ☐ Interstitial Cystitis / Painful Bladder
- ☐ Constipation, IBS, chronic diarrhea
- ☐ Chron's Disease
- ☐ Joint problems
- ☐ Abdominal pain
- ☐ Emphysema/bronchitis
- ☐ Sexually transmitted diseases
- ☐ HIV/AIDS
- ☐ Fecal incontinence
- ☐ Smoking habit
- ☐ Blood in urine
- ☐ Trouble feeling bladder fullness
- ☐ Pelvic Organ Prolapse
  - o Type:
  - o Grade:
- ☐ Cancer: Type:
  _____
- ☐ Sleep Disorders
- ☐ Drug Addiction
- ☐ Fatigue, Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Allergies:
  _____
- ☐ Other (please list)

- ☐ _____

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OB/GYN History (if appropriate):

Contraceptive History – Currently using a form of birth control? Y / N

Type of contraception used (condom / pill / IUD / implantable / cervical fluid): _____

If oral contraceptives, how long were they taken? _____

Vaginal deliveries: _____# C-sections _____ # Episiotomies _____ Forceps Y / N

Complications with delivery / post-partum: _____

Pelvic Surgical History: _____

_____

Menstrual History: Age at onset? _____ Date of last menstrual cycle? _____

Y/N Painful periods?
Y/N Regular cycles?
Y/N Pain with tampon insertion?
Y/N Pain with ovulation?
Y/N Menopause?
Y/N Hormonal Treatment?

Any other significant factors in OB/GYN history, please describe:

_____

_____

Sexual Function: For pelvic health, sexual function is an important component to be addressed. These questions are helpful in creating a complete treatment plan for you. However, please know you may choose not to disclose any portion of the following information.

Please circle any applicable items:

Are you currently sexually active? Y / N / It's complicated

Orgasm, erectile, clitoral function – circle any that apply:

Premature ejaculation
Painful penetration (vaginal / rectal)
Difficulty with erection
Painful ejaculation
Nocturnal erections
Lack of orgasm
Pain with orgasm
Arousal without completion
Low libido / lack of desire

Y/N History of sexual abuse?
Y/N Leakage of urine during intercourse?
Y/N Latex allergy?
Y/N Lubricant allergy / sensitivity

If you use a vaginal or rectal lubricant, what type do you use? _____

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Bladder/Bowel Habits:

Number of times you urinate during the day? 3-5 6-9 10-13 >13

Number of times you urinate after going to bed? 0 1-2 2-3 >3

# of bowel movements per day? 0-1 1-2 2-3 >3

Consistency of stool: Loose Normal Hard

Y/N Do you take your time to empty your bladder?
Y/N Can you stop the flow of urine?
Y/N Do you strain to pass urine?
Y/N Do you strain to pass feces?
Y/N Do you empty your bladder frequently, before the urge?
Y/N Do you ignore the urge to defecate?
Y/N Does your bladder feel full after urination?
Y/N Do you have a slow, hesitant urine stream?
Y/N Do you have triggers that make you feel you can't wait to urinate or defecate?

Fluid Intake per day (one glass is 8 oz or one cup): 1-2 2-3 3-4 4-5 >5
Number of Caffeinated glasses per day: 0 1-2 2-3 3-4 4-5 >5
Number of Alcoholic glasses per day: 0 1-2 2-3 3-4 4-5 >5

Urine/Fecal Leakage Questions:

Number of urinary leakages daily: 1 2 3 4 5 >5

Number of fecal/bowel leakages daily: 1 2 3 4 5 >5

Severity of Leakage: None Few drops Wets underwear Wets outerwear

Protection worn: None Minipad Maxipad Full undergarment

Position or Activity with Leakage:

Vigorous activity
Light activity
Changing positions
Walking to toilet
Strong urge to go
Intercourse or sexual activity
No activity changes leakage (constant)

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Pelvic Pain Questions:

"I have pain with…"

Sexual intercourse	Standing
Urination	Tight clothes
Defecation	Exercise
At Rest	Menstruation
Sitting	Orgasm

"Pain is located…."

Deep	Penile tip	Rectum
Surface	Clitoris	Tailbone / Coccyx
Vagina	Labia	Tailbone / Sacrum
Urethra	Scrotum	Pubic bone
Anus	Hip	Right side / Left side /
Penile shaft	Pubic	Both sides

Approximate pain onset date: _____

Pain is relieved by: _____

Pain is worsened by: _____

Medications, supplements, herbals or topicals: _____

_____

Due to privacy regulations, we require your permission to email you and to leave messages on your answer machine (re: appointment reminders and/or rescheduling appointments) or with any individual who answers the number you provide, identifying ourselves as "Provenance Rehabilitation." Do we have your permission to leave such messages and to email you? → Yes → No Initials: _____

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Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred to for evaluation and treatment of pelvic floor dysfunction. I understand that to evaluate and treat my condition it may be necessary, initially and periodically, to have my physical therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length. I understand that no guarantees have been or can be provided regarding the success of therapy. I hereby request and consent to the evaluation and treatment to be provided by the physical therapists of Provenance Rehabilitation.

Patient Name (Please Print): _____

Patient Signature: _____Date: _____

Signature of parent or guardian (if applicable): _____

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