

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 that are relevant to our practice.



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

Marietta / East Cobb
4343 Shallowford Rd, Ste G3
Marietta, GA 30062

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 \$150.00 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 _____

Alpharetta / North Fulton - Directions to our Facility

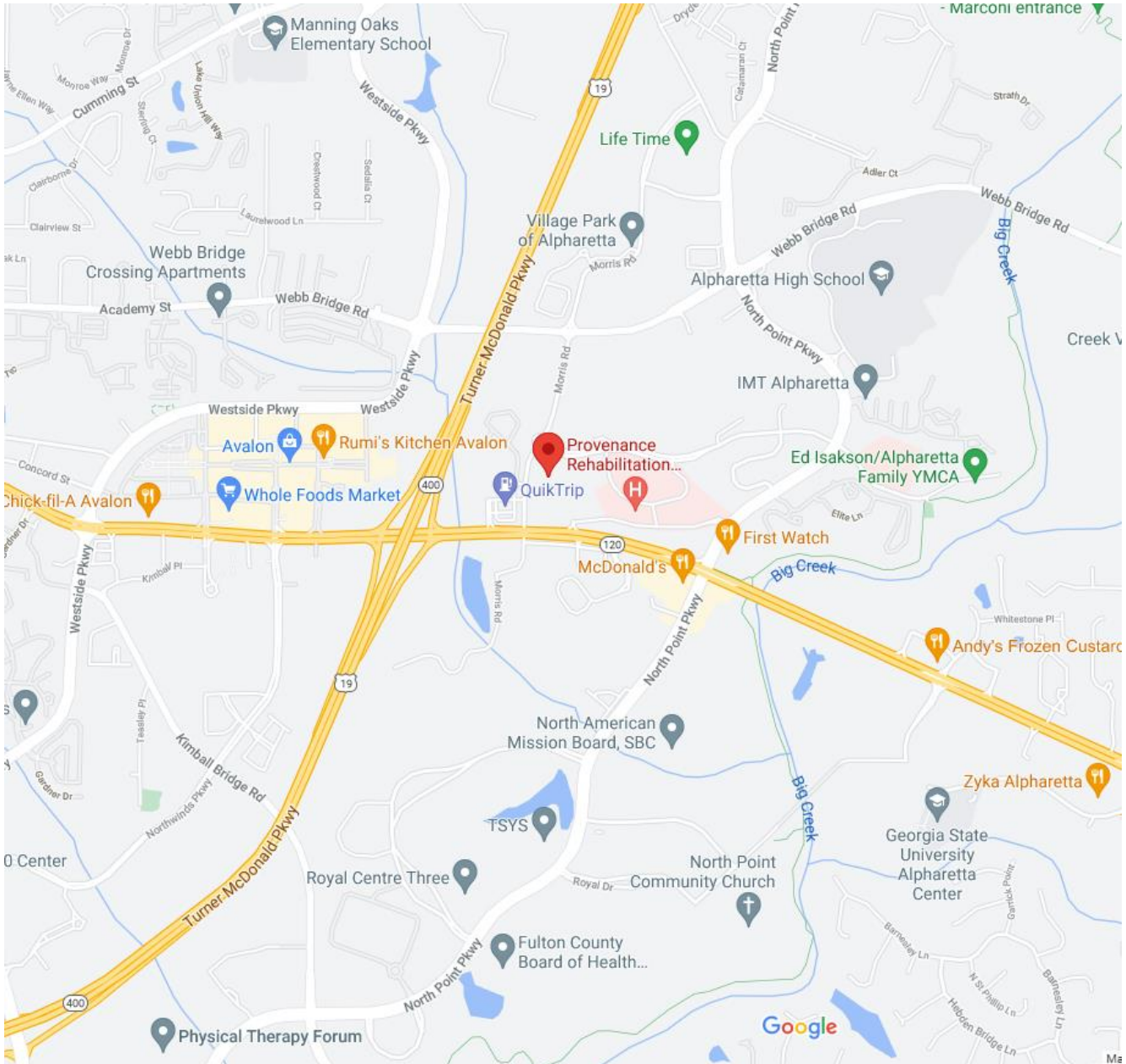
Driving north on GA-400:

- 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 Parkway 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.
- We are located in Suite 310A, 3rd floor.

Alpharetta / North Fulton Location



Marietta / East Cobb - Directions to our Facility

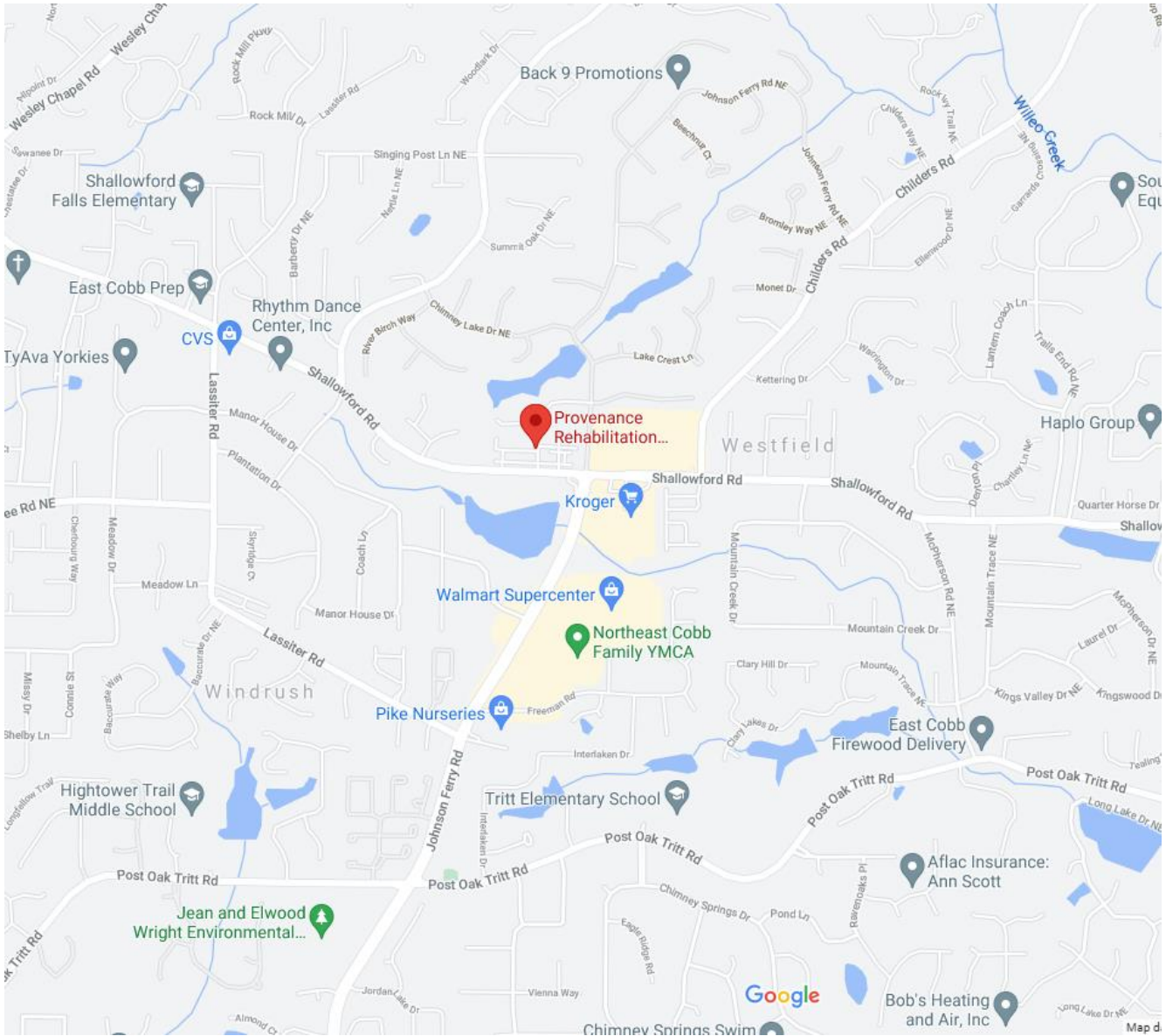
Driving west from Roswell:

- From Highway 9, take Magnolia Street (in downtown Roswell) which will turn into Pine Grove Road and head west until Pine Grove Road becomes Shallowford Road
- You will cross over Johnson Ferry Road to which you will then want to take the second entrance into the office park – you will see a Tritt Animal Hospital and Renew Day Spa signs for the office park.
- We are located in Suite G-3.

Driving east from Marietta:

- Take Highway 120 / Roswell Road east to Johnson Ferry Road or Sandy Plains Road east until it turns into Shallowford Road.
 - 1) If taking Highway 120 / Roswell Road east, take a left or head north on Johnson Ferry Road to Shallowford Road. Turn left at this traffic light onto Shallowford Road. The office will be immediately on the right side in the office park.
 - 2) If taking Sandy Plains Road east, continue until Shallowford Road. Take a right on Shallowford and continue to the office. The office will be on the left side.
- We are in an office park where you will see signs for Tritt Animal Hospital and Renew Day Spa signs.
- We are located in Suite G-3.

Marietta / East Cobb Location



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?

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

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 Pain with ovulation? _____

Y/N Regular cycles? _____ Y/N Menopause? _____

Y/N Pain with tampon insertion? _____ 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

Lack of orgasm

Painful penetration (vaginal / rectal)

Pain with orgasm

Difficulty with erection

Arousal without completion

Painful ejaculation

Low libido / lack of desire

Nocturnal erections

Y/N History of sexual abuse?

Y/N Latex allergy?

Y/N Leakage of urine during intercourse?

Y/N Lubricant allergy / sensitivity

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

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 Does your bladder feel full after urination?

Y/N Can you stop the flow of urine?

Y/N Do you have a slow, hesitant urine stream?

Y/N Do you strain to pass urine?

Y/N Do you strain to pass feces?

Y/N Do you have triggers that make you feel you can't wait to urinate or defecate?

Y/N Do you empty your bladder frequently, before the urge?

Y/N Do you ignore the urge to 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

Strong urge to go

Light activity

Intercourse or sexual activity

Changing positions

No activity changes leakage (constant)

Walking to toilet



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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): _____