Pelvic Wellness CENTER

Restoring function through physical therapy

Patient History

Name _____ **Age**_____ **Date**_____

1. Describe the current problem that brought you here?_____
_____

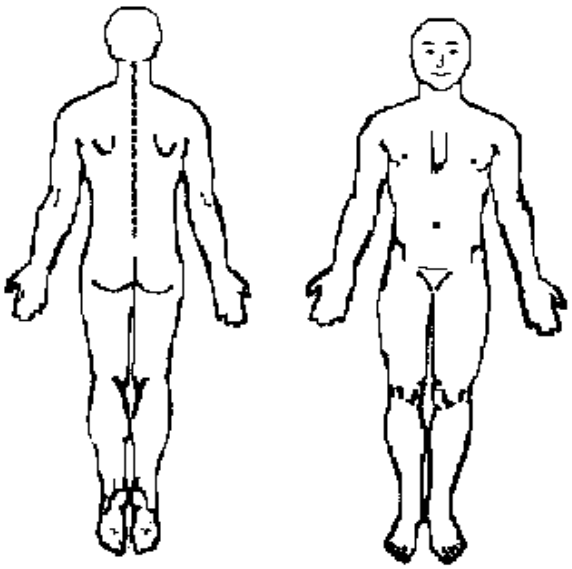
2. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst __

3. When did your problem first begin? ____months ago or ___ years ago.

4. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____
_____

5. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how?_____

6. If pain is present rate pain on a 0-10 scale 10 being the worst._____ Describe the nature of the pain and mark on the following diagram to indicate location(s) (i.e. constant burning, intermittent ache)_____



7. Describe previous treatment/exercises_____
_____

Pg 2 History **Name**_____

8. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than_____ minutes
___ Walking greater than _____minutes
___ Standing greater than _____ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list_____

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers -running water/key in door
___ With nervousness/anxiety
___ No activity affects the problem

_____

9. What relieves your symptoms?_____

_____

_____

10. How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
Mental Health: Current level of stress High___ Med___ Low___ Current psych therapy? Y/N
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____

11. Have you ever had any of the following conditions or diagnoses? circle all that apply

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression/anxiety	Rheumatoid Arthritis	Hepatitis
Anorexia/bulimia	Joint Replacement	Sexually transmitted infection
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain
HIV/AIDS		

Other/Describe_____

12. Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling
Y/N	Other /describe_____		

_____

Page 3 Symptoms **Name**_____

13. Date of Last Physical Exam _____ Tests performed_____
_____

14. Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

15. Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries #___	Y/N	Vaginal dryness
Y/N	Episiotomy #___	Y/N	Painful periods
Y/N	C-Section #____	Y/N	Menopause - when? ___
Y/N	Difficult childbirth #_____	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain
Y/N	Other /describe_____		

16. Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic pain		
Y/N	Other /describe_____		

17. Bladder / Bowel Habits / Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine
Y/N	Urinary intermittent /slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections
Y/N	Other/describe _____		

Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? ___minutes, ____hours, ___not at all

The usual amount of urine passed is: ___small ___ medium___ large.

Frequency of bowel movements _____ times per day, _____times per week

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all.

If constipation is present describe management techniques _____

Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated?_ glasses per day.

Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
___None present
___Times per month (specify if related to activity or your period)
___With standing for _____ minutes or _____hours.
___With exertion or straining
___Other

Skip questions if no leakage/incontinence

Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

What form of protection do you wear? (Please complete only one)
___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
___Other _____
On average, how many pad/protection changes are required in 24 hours? _____# of pads

18. Medications - pills, injection, patch Start date Reason for taking
_____
_____
_____
_____

19. Over the counter -vitamins etc Start date Reason for taking
_____
_____
_____
_____
_____

20. What are your physical therapy treatment goals/concerns?_____
_____

21. Anything else you would like your therapist to know? Add below
_____
_____
_____
_____
_____
_____
_____
_____

Financial Policy

Pelvic Wellness Center thanks you for choosing us to be part of your health care. We have a strong commitment to ensure your experience with us meets your needs. We ask that you please take a few moments to review our financial policy in hopes to minimize any miscommunications or misunderstandings regarding your financial obligations.

INSURANCE

As a courtesy to our patients, we will submit claims for you unless our clinic is considered ''out of network''. If our clinic is ''out of network'' we will supply you with a superbill so you able to submit for reimbursement.

We will verify your insurance. We cannot guarantee the accuracy of the information we receive from your insurance carrier, nor is it a guarantee of payment. You should contact your insurance company directly with specific questions regarding your policy. Your insurance is a contract between you and your insurance company. You are ultimately responsible for your bill.

If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will assist in most cases with the preauthorization process and obtaining a referral. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company, or non- payment. You may be responsible for payment for services in this case.

CASH PAYMENT DISCOUNT

Cash payment arrangements are for those patients choosing to not to have Pelvic Wellness Center bill insurance directly for services rendered. Our fee for cash visit is $125.00 per visit for 45 min to one hour session, due at the time of service.

CHANGES IN YOUR INSURANCE

We cannot bill your insurance unless we have the most accurate information from you regarding your insurance coverage. It is your responsibility to inform us immediately of any changes if you would like us to bill insurance. Failure to do so may result in denial of coverage. You will be responsible to pay full balance.

PAYMENTS

You are responsible for payments of all co-payments, deductibles and co-insurances associated with your plan for physical therapy. Co-payments are due at the time of service. A $125.00 to $150.00 payment toward your deductible will be due at the time of your first visit, effective for new patients seen after January 1, 2014.

We aim to provide you with a monthly statement. If you have insurance, balances will be considered current from the date your insurance pays its portion. Unpaid balances beyond 120 days may be referred to collections. **We will work with you to avoid sending your account to collections.**

We accept cash, checks, and credit cards for payment. We reserve the right to charge $25.00 fee for all returned checks.

CANCELLATION POLICY

In order to achieve maximum benefit from your physical therapy, it is important to maintain regular visits as prescribed by your therapist.

If you must cancel, you need to provide a 24 hour notice. If you cancel less than 24 hours in advance, you will be responsible for a cancellation fee of $50 fee for weekday appointments, and $75 fee for Saturday appointments. This includes “no show” appointments. Your therapist may use her discretion if the reason for your cancellation is unavoidable. **This payment is not billable to insurance**. Failure to contact office within 48 hrs of no show visit will result in cancellation of all remaining appointments.

Pelvic Wellness Center reserves the right to change or amend this financial policy at any time.

I have read and agree to the above financial policy

Date:_____ Patient Name(Please Print): _____

Signature of Patient or Guardian:_____

_____ Please initial that you have received a copy of this financial policy to take home for your reference

Pelvic Wellness CENTER

Restoring function through physical therapy

Pelvic Floor Consent for Evaluation and Treatment

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy evaluation and treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may also include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to the following: observation, palpation, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks:

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

Potential benefits:

I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives:

If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Cooperation with treatment:

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.
I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated.

Date_____ Patient Name (print): _____

Signature of Parent or Guardian (If applicable):_____

Pelvic Wellness CENTER

Restoring function through physical therapy

Acknowledgment of Receipt of Privacy Practices

I, _____ have received or waived my right to receive a copy of Pelvic Wellness Center's Notice of Privacy Practices with an effective date of April 15, 2003.

Signature of Patient (or guardian)_____Date_____

Signature of Witness_____Date_____