

# Pelvic Wellness CENTER

Restoring function through physical therapy  
Pelvic Wellness Center  
1655 Capitol St NE  
Salem, OR  
503.983.8811

## Patient History

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

1. Describe the current problem that brought you here? \_\_\_\_\_  
\_\_\_\_\_

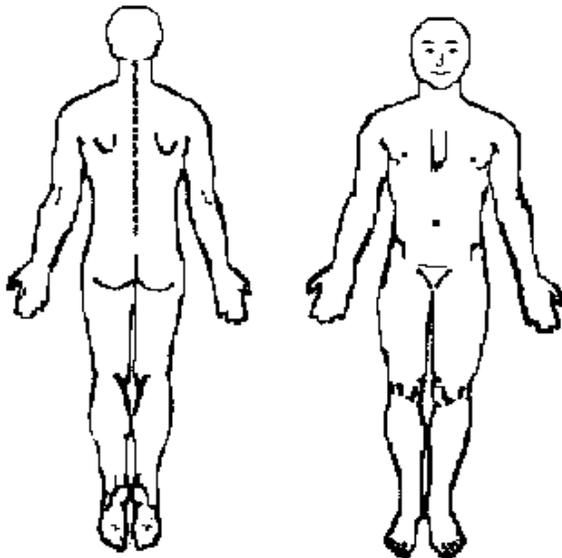
2. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst \_\_\_\_

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(e.g. constant burning, intermittent ache) and mark on the following diagram to indicate  
location(s) \_\_\_\_\_



7. Describe previous treatment/exercises \_\_\_\_\_  
\_\_\_\_\_

**Pg 2 History**

**Name** \_\_\_\_\_

8. Activities/events that cause or aggravate your symptoms. Check/circle all that apply
- |  |   |
|--|---|
| <input type="checkbox"/> Sitting greater than _____ minutes                | <input type="checkbox"/> With cough/sneeze/straining              |
| <input type="checkbox"/> Walking greater than _____ minutes                | <input type="checkbox"/> With laughing/yelling                    |
| <input type="checkbox"/> Standing greater than _____ minutes               | <input type="checkbox"/> With lifting/bending                     |
| <input type="checkbox"/> Changing positions (ie. - sit to stand)           | <input type="checkbox"/> With cold weather                        |
| <input type="checkbox"/> Light activity (light housework)                  | <input type="checkbox"/> With triggers -running water/key in door |
| <input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump) | <input type="checkbox"/> With nervousness/anxiety                 |
| <input type="checkbox"/> Sexual activity                                   | <input type="checkbox"/> No activity affects the problem          |
| <input type="checkbox"/> Other, please list _____                          |   |

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.

**Page 4 Pelvic Symptom Questionnaire**

**Name** \_\_\_\_\_

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

<u>18. Medications - pills, injection, patch</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>19. Over the counter -vitamins etc</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

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## 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 upon request.

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.

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 or Fee for Service arrangements are for those patients choosing to not to have Pelvic Wellness Center bill insurance directly for services rendered. Our fee for a visit is \$135.00 per visit for 45 minutes to one hour session, due at the time of service. You may request a superbill to submit to insurance for reimbursement. Pelvic Wellness Center does not guarantee or assist with any "out of network" submissions beyond providing a superbill.

### **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 visits.

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.

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)

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## 48 Hour Notice 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 **48 hour** notice. If you cancel less than 48 hours in advance, you will be responsible for a cancellation fee of \$75.00 fee for weekday appointments, and \$100.00 fee for Saturday appointments. This includes "no show" appointments. **This payment is not billable to insurance.** Failure to contact office within 24 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)

\_\_\_\_\_  
Patient Signature of Parent or Guardian (if applicable)

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

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## 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

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 an evaluation or to be treated.

Date \_\_\_\_\_ Patient Name (print): \_\_\_\_\_

Signature of Parent or Guardian (If applicable): \_\_\_\_\_

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**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 \_\_\_\_\_