mti physical therapy
MANUAL THERAPY • ORTHOPEDICS • SPORTS

PELVIC HEALTH & PERFORMANCE CENTER

Patient History

Name_____ **Age** _____**Date** _____

What are your pronouns?
☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Ze/hir/hirs ☐ Another pronoun:_____
What is your gender identity?
☐ Male ☐ Female ☐ Gender nonconforming ☐ Transgender man/Transman
☐ Transgender woman/Transwoman ☐ Additional identity: _____
What sex were you assigned at birth? ☐ Male ☐ Female ☐ Decline to state

Describe the current problem that brought you here:
_____
_____
When did your problem first begin?____months ago, or ____years ago, other: _____
Was your first episode of the problem related to a specific incident? Y/N
Please describe and specify date:
_____
_____
Since that time, is it ____ staying the same, ____ getting worse, ___ getting better?
Why or how?
_____
_____
If pain is present, rate the pain from 0-10, with 0 being no pain and 10 being the worst:
_____
Describe the nature of the pain (e.g., constant burning, intermittent ache) and its location:
_____
_____
Describe any previous treatment/exercises:
_____
_____
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 (e.g., sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ With triggers (e.g., running water)
___ Other, please list:

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ Sexual activity
___ With nervousness/anxiety
___ No activity affects the problem

_____
What relieves your symptoms?
_____
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: _____

Rate the severity of this problem from 0-10, with 0 being no problem and 10 being the worst:

_____

What are your treatment goals/concerns?

_____

_____

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: _____		

General Health History

Date of Last Physical Exam: _____ Tests performed: _____

_____

Overall Health: ___ Excellent ___Good ___ Average ___ Fair ___ Poor

Occupation: _____ Hours/week_____ On disability or leave? _____

Activity Restrictions? _____

How many hours do you sleep a night on average? _____

Mental Health: Current level of stress: ___ High ___ Medium ___ Low

Are you currently in counseling or therapy? Y/N Are you interested in counseling or therapy? Y/N

Do you feel that you manage your stress well? Y/N

Activity/Exercise: ___ None ___ 1-2 days/week ___ 3-4 days/week ___ 5+ days/week

Describe _____

Have you ever had any of the following conditions or diagnoses? Circle all that apply /describe

Cancer	Stroke	Emphysema/Chronic Bronchitis
Heart Problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple Sclerosis	Allergies (please list)
Ankle Swelling	Head Injury	Latex Sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low Back Pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone Pain	Fibromyalgia	Diabetes
Alcoholism/Drug Abuse	Arthritic Conditions	Kidney Disease
Childhood Bladder Issues	Stress Fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis
Postpartum Depression (PPD)	Ehlers Danlos Syndrome	HIV/AIDS
Anorexia/Bulimia	Joint Replacement	Sexually Transmitted Disease
Smoking History	Bone Fracture	Physical or Sexual Abuse
Vision/Eye Problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing Loss	TMJ/ neck pain	Pelvic Pain
Hemorrhoids	Varicose Veins	Food Sensitivities (please list)

Other/Describe:_____

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 gender specific organs	Y/N	Surgery for your abdominal organs

Other/describe:_____

_____

Obstetric/Gynecological History

Current Status:

___ I have given birth in the last year.

I am _____ weeks/months postpartum; I gave birth on (date): _____

Did you experience any problems during this pregnancy? Y/N (if yes, please specify).

_____

If you had a perineal tear, do you know what grade tear? Y/N _____

If you had a cesarean, was it planned (meaning you did not have labor before the procedure)? Y/N

Are you experiencing problems at the site of cesarean, episiotomy, or perineal tear? Y/N (if yes, please specify). _____

___ I am not pregnant (if checked, continue to the next page)

___ I recently experienced a miscarriage

Date of miscarriage: _____

Any additional information that you feel comfortable sharing:

_____

_____

___ I am <u>currently</u> pregnant.

I am at ___ weeks gestation, with the due date of: _____

I have had concerns during this pregnancy: Y/N (if yes, please specify).

_____

Has your physician placed you on any restrictions? Y/N (if yes, please specify).

_____

Have you experienced any problems during previous pregnancies? Y/N (if yes, please specify).

Fill out this section ONLY if you have given birth in the last 12 weeks. Place a check mark next to your response.

<u>In the last 7 days:</u>

I have blamed myself unnecessarily when things went wrong.

_____ Yes, all the time
_____ Yes, most of the time
_____ No, not very often
_____ No, not at all

I have felt panicky or scared for no very good reason.

_____ Yes, all the time
_____ Yes, most of the time
_____ No, not very often
_____ No, not at all

I have been anxious or worried for no good reason.

_____ Yes, all the time
_____ Yes, most of the time
_____ No, not very often
_____ No, not at all

Therapist: Score <u>Yes all</u> 3 pts, <u>Yes most</u> 2 pts, <u>Not often</u> 1 pt, <u>Not at all</u> 0 pts. Add and multiply total by 10/3. Referral for a score of >/= 10 pts.

Pelvic Health History (answer all that apply)

Number of pregnancies____ miscarriages ____ vaginal births ____ cesareans ____
Number of episiotomies _____ Number of vacuum/forceps-assisted deliveries _____
Y/N Did you ever experience tearing or need stitches?
Y/N Did you ever have a difficult childbirth or traumatic delivery?

Have you ever had any of the following?

Y/N Pain with vaginal penetration
Y/N Vaginal dryness
Y/N Menopause (if yes, beginning at what age? _____)
Y/N Prolapse or sensation of organs "falling out"
Y/N Pelvic pain
Y/N Painful periods (if yes, beginning at what age? _____)

For those who were assigned male at birth, have you ever had the following?

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

Medications (pill, patch, injection):	Reason for Taking

Over the Counter (vitamins, supplements):	Reason for Taking

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Other/describe _____

Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections

1. **Frequency of urination**: awake hours ____ times per day, sleep hours ____times per night
2. **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
3. **The usual amount of urine passed is**: ___small ___ medium___ large.
4. **Frequency of bowel movements**: ____ times per day, _____times per week, or _____.
5. **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.
6. **If constipation is present, describe management techniques**: _____
7. **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.
8. **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 the following questions if there is no leakage/incontinence:

9a. **Bladder leakage - number of episodes**
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. **Bowel leakage - number of episodes**
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. **On average, how much urine do you leak?**
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b. **How much stool do you lose?**
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

11. **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 _____

12. **On average, how many pad/protection changes are required in 24 hours**? ____ # of pads

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CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. 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 or bladder functions, sacroiliac conditions, sexual dysfunction, and/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 primarily by observing and/or palpating the perineal region, including the vagina and/or rectum externally and /or internally. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar and nerve mobility and tenderness, as well as the function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization, breathing/relaxation techniques, and educational instruction.

Potential risks: I may experience a temporary increase in my current level of pain or discomfort, emotional distress, 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 physical 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 attend all of my scheduled therapy appointments, unless there are unusual circumstances that prevent me from doing so. I agree to cooperate with and follow the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

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CONSENT ACKNOWLEDGMENT AND WAIVER

I, _____, give my consent for _____("Therapist") to perform a vaginal and/or rectal examination for the purposes of evaluating my condition and providing therapeutic treatment. **I hereby acknowledge the following by initialing below:**

_____ I am 18 years or older;

_____ I have been examined by a physician for this condition and assured that there is no underlying medical cause for this condition, beyond what a physical therapist can be reasonably expected to treat;

_____ This examination and treatment involves extremely sensitive touching, both internally and externally;

_____ I understand that I can terminate the procedure at any time;

_____ I understand that I am responsible for informing the examiner if I experience any unusual symptoms or any type of discomfort during the procedure;

_____ I understand that, given the nature of the treatment, I have the option of having a second person present in the room during treatment. This person could be a family member, friend, or clinic staff member. Please indicate your preference with your initials.

_____ Yes, I would like to have an additional person present.
_____ Yes, I would like to have another clinic staff member present.
_____ No, I would not like an additional person present.

Please inform the therapist if you are pregnant, have an infection of any kind, have an IUD or other implants, a sexually transmitted disease, are less than 6 weeks post-partum or post- surgery, have severe pelvic pain or have sensitivity to lubricant, vaginal creams, or latex, prior to the pelvic floor assessment.

Patient Signature Date

Therapist Signature Date

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PELVIC HEALTH & PERFORMANCE CENTER
FINANCIAL POLICY

PLEASE READ CAREFULLY AND SIGN

Please note that we do not contract with any insurance providers. The Pelvic Health & Performance Center (PHPC) is a small, fee-for-service center. In order to provide one-to-one, high-quality care, we are out of network with all insurances including Medicare and Medicaid. **Payment is due at the time of service**. We accept Visa and MasterCard (we cannot collect cash or checks at time of service) – upon booking your appointment, you will be asked to securely enter your credit card information for your convenience. Your card will automatically be charged after your appointment is completed.

You may be able to request insurance reimbursement after your appointment. It is your responsibility to know the limitations and restrictions of your insurance company regarding out of network physical therapy. Upon request, the PHPC can provide you with a "Super Bill" that you can use to request reimbursement. The PHPC will not request reimbursement on your behalf – you will need to do so yourself. You are responsible for paying your balance at time of service regardless of your insurance company's payments for our of network care.

In the event it should become necessary to forward your unpaid balance to a collection agency, you agree to pay interest and collection fees. If legal action is taken against your account, you agree to pay all reasonable attorney fees, filing fees and any other costs associated with this action. Checks returned without sufficient funds will be charged a $35.00 fee.

By signing below, I attest that I have read and agree to the Pelvic Health & Performance Center's financial policy.

_____ _____

Signature of Patient or Legal Guardian ***Date***

Missed Appointments & Cancellations: appointments not kept or cancelled without 24 hours notice prior to the scheduled appointment time will be charged a **$150.00** cancellation fee. These charges cannot be billed to your insurance company and will be your responsibility. Missed appointment fees must be paid at the next scheduled appointment. If you miss 3 appointments without proper notice, all future appointments will be cancelled.

_____ _____

Signature of Patient or Legal Guardian ***Date***

PRIVACY POLICIES STATEMENT/HIPAA

You have the opportunity to review and question our privacy policies statement at your request. This statement outlines our policies that protect your privacy. We will release your personal health information for billing purposes to be reimbursed for services rendered or to facilitate your care with another of your health care providers. You may request (inwriting) to prevent us from doing so without penalty or cessation of your care. If you exercise this right, you will be responsible for your balance and it will be your responsibility to submit claims to your insurance carrier for reimbursement.

_____ _____

Signature of Patient or Legal Guardian ***Date***

SCREENING FOR PATIENT WITH LOW BACK PAIN AND HIP PAIN

Do you urinate more than 8 times a day?	• Yes	• No
Do you have difficulty initiating urination?	• Yes	• No
Do you have burning with urination?	• Yes	• No
Do you feel that your bladder is not emptied after you have urinated?	• Yes	• No
Do you experience any urine loss (on way to bathroom or coughing/sneezing)?	• Yes	• No
Do you feel pelvic pressure?	• Yes	• No
Do you have less than one bowel movement every 3 days?	• Yes	• No
Do you have to strain or facilitate to have a bowel movement?	• Yes	• No
Is your stool lumpy/hard or does it have cracks on it?	• Yes	• No
Do you have pain during or after a bowel movement?	• Yes	• No
Do you experience painful intercourse?	• Yes	• No
Do you experience pelvic pain (e.g., vaginal, rectal, penile, testicular, perineal or pelvic)?	• Yes	• No
Do you have pelvic pain with sitting?	• Yes	• No

Have you ever been diagnosed with one or more of the following conditions?

• Vulvodynia	• Dyspareunia	• Endometriosis
• Vestibulodynia	• Interstitial Cystitis	• Pudendal Neuralgia
• Vaginismus	• Chronic Prostatitis	• Chronic Pelvic Pain
• Levator Ani Syndrome	• Piriformis Syndrome	• Coccydynia
• Proctalgia Fugax	• Urethral Syndrome	• Bladder Sphincter Dysenergia

If you answered **YES** to any of the above questions, problems with your pelvic floor muscles, fascia or nerves may be contributing to your symptoms/pain. You may be a candidate for an assessment from a physiotherapist with appropriate training to assess your pelvic floor through internal palpation (vaginal or rectal exam). Please speak to your treating health care provider for more details.