Art of Health Physical Therapy, P.C.

Pelvic Floor Intake

Name:_____ **Date**_____

Address_____

Home Phone#_____ Cell Phone#_____

Date of Birth_____ Age_____ E-mail_____

Referring Physician_____

Address_____

Tel#_____ Fax#_____

Primary Physician_____

Address_____

Tel#_____ Fax#_____

1.Describe the current problem that brought you here _____

_____

2.When did your problem first begin?_____months/years ago

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

_____

4.Since that time is your symptoms: ❑same ❑getting worse ❑getting better?
Why or how?_____

_____

5.If pain is present, rate pain on a 0-10 scale (0=no pain;10=worst pain):._____

6.Describe the nature of the pain: ❑constant ❑intermittent ❑burning ❑ache
❑soreness ❑muscle spasms ❑stabbing

Others_____

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Name _____ **Date**_____ **(page 2)**

7.Previous treatment for your condition: ❑PT ❑Chiropractor ❑Acupuncturist
❑Psych ❑Nutritionist ❑Colorectal
❑Pain mgmt ❑Urogynecologist
Others_____

8.Activities that cause or aggravate your symptoms. **Check all that apply**

❑Sitting greater than_____ minutes
❑Cough/sneeze/straining
❑Walking greater than _____minutes
❑Laughing/yelling
❑Light activity (light housework)
❑Vigorous act/exercise (run/weight lift/jump)
❑With nervousness/anxiety
❑Changing positions (sit to stand)
❑Lifting/bending
❑Standing greater than_____minutes
❑Cold weather
❑Sexual activity
❑With triggers (running water/key in door)
❑No activity affects the problem
Others please specify_____

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 _____

11.Rate the severity of this problem from ***0 -10 with 0=no problem and 10=worst*** _____

12.What are your treatment goals/concerns?_____
_____

13.Since the onset of your current symptoms have you had: (check all that apply)

❑Fever/Chills
❑Unexplained weight change
❑Dizziness or fainting
❑Change in bowel/bladder functions
❑Malaise (Unexplained tiredness)
❑Unexplained muscle weakness
❑Night pain/sweats
❑Numbness / Tingling
Others (describe)_____
_____

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Name _____ **Date** _____ **(page 3)**

14.**Health History:** Date of Last Physical Exam _____
Tests performed (if any) _____

15.**General Health:** ❑Excellent ❑Good ❑Average ❑Fair ❑Poor
Occupation _____ Hrs/wk _____ ❑Not working ❑Retired
16.**Mental Health**: Current level of stress ❑High ❑Med ❑Low
Are you currently receiving psychological therapy? ❑Yes ❑No

17.**Activity/Exercise**: ❑None ❑1-2 days/wk ❑3-4 days/wk ❑5+ days/wk
Describe _____

18.**Have you ever had any of the following conditions or diagnoses? (check all that apply /describe)**

❑Cancer	❑Stroke	❑Emphysema
❑Heart problems	❑Epilepsy/seizures	❑Asthma
❑High blood pressure	❑Multiple sclerosis	❑Chronic bronchitis
❑Ankle swelling	❑Head Injury	❑Latex sensitivity
❑Anemia	❑Osteoporosis	❑Hypothyroid/
❑Hyperthyroid	❑Low back pain	❑Headaches
❑Chronic fatigue syndrome	❑Sacroiliac/tailbone pain	❑Diabetes
❑Alcoholism/drug problem	❑Arthritic conditions	❑Kidney disease
❑Childhood bladder problems	❑Stress fracture	❑Irritable Bowel Synd
❑Depression	❑Hepatitis HIV/AIDS	❑Rheumatoid Arthritis
❑Anorexia/bulimia	❑Joint Replacement	❑Sexuallytransmitted dz
❑Smoking history	❑Bone Fracture	❑Physical/sexual abuse
❑Vision/eye problems	❑Sports Injuries	❑Raynaud's/cold hands/feet
❑Hearing loss/problems	❑TMJ/ neck pain	❑Pelvic pain

Other/Describe _____
Allergies _____

19.**Surgical /Procedure History: (please check all that apply & specify dates)**

❑back/spine surgery _____	❑bladder/prostate surgery _____
❑brain surgery _____	❑bones/joints surgery _____
❑abdominal surgery _____	❑Other/describe _____

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Name _____ **Date**_____ **(page 4)**

20. Ob/Gyn History: (for Male Clients, please skip to #21)

❑Childbirth vaginal deliveries #_____
❑C-Section #_____
❑Episiotomy #_____
❑Prolapse or organ falling out
❑Yeast infection
❑vaginal dryness
❑Painful periods
❑Menopause- age?____
❑Pelvic pain
❑Urinary tract infection

❑Painful vaginal penetration. When ❑initial penetration ❑thrusting ❑afterwards

Do you use lubrication during intercourse? _____If so, which one?_____

Others (please describe)_____

Period: ❑Regular ❑Irregular ❑heavy bleeding ❑cramping

❑Need to take medication during your period because of the pain?
If so, which one?_____

21. Medications (pills, injection, patch) Start date Reason for taking

_____

_____

_____

_____

Pelvic Symptom Questionnaire

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

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Name _____ **Date**_____ **(page 5)**

1.Frequency of urination: awake hour's _____X per day, sleep hours _____X 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 _____X per day, _____X per week

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=8 oz or one cup**) _____glasses/day
Of this total how many glasses are caffeinated? _____glasses/day

Skip questions if NO leakage/incontinence:
8a.Bladder leakage: _____# of episodes ❑daily ❑weekly ❑monthly ❑None
Only with: ❑physical exertion ❑cough ❑sneeze ❑lifting ❑sit to stand

8b. On average, how much urine do you leak? ❑Not applicable
❑Just a few drops ❑Wets underwear ❑Wets the floor

9a. Bowel leakage: _____# of episodes❑daily ❑weekly ❑monthly ❑None

9b. How much stool do you lose? ❑Not applicable
❑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, maxi pad)
❑Maximum protection (specialty product/diaper)
On average, how many pad/protection changes are required in 24 hours?_____# of pads

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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 post surgical scars, persistent sacroiliac or low back pain or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, that my physical therapist performs 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 and/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, 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 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 physical therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records: I authorize Art of Health Physical Therapy, PC the release of my medical records to my physicians/primary care provider or insurance company.

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

Cancellation/No-Show Policy: I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I ***cancel less than 24 hours in advance, I will pay a cancellation fee of $95.00 A No-Show will incur the FULL charge for the visit.***

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 physical 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 physical therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapist of Art of Health Physical Therapy, PC.

Date **Patient Name:** _____

(Please Print)

_____ _____

Patient Signature Signature of Parent or Guardian (If applicable)

_____

Witness Signature

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