Pelvic Wellness CENTER

Restoring function through physical therapy

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PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms

Your answers to the following questions will help us to manage your child's care better. Please complete all pages **prior to** your child's appointment. Thank You!

Name of parent or guardian completing this form_____

Child's name:_____Prefers to be called _____ Date: _____

Age _____Grade_____Height _____Weight_____

Describe the reason for your child's appointment_____

_____

_____

_____

_____

_____

When did this problem begin? _____Is it getting better__worse_____staying the same _

Name and date of child's last doctor visit _____

Date of last urinalysis_____

Previous tests for the condition for which your child is coming to therapy. Please list tests and results_____

_____

_____

_____

_____

Medications	Start date	Reason for taking

Has your child stopped or been unable to do certain activities because of their condition? For example, embarrassed to play with friends, can't go on sleepovers, feels ashamed about leakage and avoids play dates. _____

_____

_____

Does your child now have or had a history of the following? Explain all "yes" responses below.

Y/N Pelvic pain
Y/N Low back pain
Y/N Diabetes
Y/N Latex sensitivity/allergy
Y/N Allergies
Y/N Asthma
Y/N Surgeries
Y/N Blood in urine
Y/N Kidney infections
Y/N Bladder infections
Y/N Vesicoureteral reflux Grade ____
Y/N Neurologic (brain, nerve) problems
Y/N Physical or sexual abuse
Y/N Other (please list)_____

Explain yes responses and include dates_____
Does your child need to be catheterized? Y/N If yes, how often? _____

Bladder Habits

1. How often does your child urinate during the day? _____times per day, every _____ hours.
2. How often does your child wake up to urinate after going to bed? _____times
3. Does your child awaken wet in the morning? Y/N If yes, _____ days per week.
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y/N
5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)
   ___ Not at all
   ___ 1-2 minutes
   ___ 3-10 minutes
   ___ 11-30 minutes
   ___ 31-60 minutes
   ___ Hours
6. Does your child take time to go to the toilet and empty their bladder? Y/N
7. Does your child have difficulty initiating the urine stream? Y/N
8. Does your child strain to pass urine? Y/N
9. Does your child have a slow, stop/start or hesitant urinary stream? Y/N
10. Is the volume of urine passed usually: Large Average Small Very small (circle one)
11. Does your child have the feeling their bladder is still full after urinating? Y/N
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet?Y/N
13. Fluid intake (one glass is 8 oz or one cup)
    ___ of glasses per day (all types of fluid)
    ___ of caffeinated glasses per day
    Typical types of drinks _____
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e. running water, etc.) Y/N please list_____

Bowel Habits

15. Frequency of movements: ___ per day ___ per week. Consistency: loose__ normal___ hard__
16. Does your child currently strain to go? Y/N
17. Ignore the urge to defecate? Y/N_____
18. Does your child have fecal staining on his/her underwear? Y/N How often?_____
19. Does your child have a history of constipation? Y/N_____How long has it been a problem?_____

SYMPTOM QUESTIONNAIRE

1. Bladder leakage (check all that apply)
   ___ Never
   ___ When playing
   ___ With strong cough/sneeze/physical exercise
   ___ With a strong urge to go
   ___ Nighttime sleep wetting
   ___Laughing/giggling
   ___Other:_____
2. Frequency of urinary leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day
   ___ Constant leakage
3. Severity of leakage (check one)
   ___ No leakage
   ___ Few drops
   ___ Wets underwear

   ___ ***Wets outer clothing***

4. Bowel leakage (check all that apply)
   ___ Never
   ___ When playing
   ___ With strong cough/sneeze/physical exercise
   ___ With a strong urge to go
   ___Other:_____

5. Frequency of bowel leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day

6. Severity of leakage (check one)
   ___ No leakage
   ___ Stool staining
   ___ Small amount in underwear

   ___ ***Complete emptying***

7. Protection worn (check all that apply)

___ None ___ Diaper

___ Tissue paper / paper towel ___ Pull-ups

8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10

0_____10

Not a problem Major problem

9. Rate the following statement as it applies to your child's life today

My child's bladder is controlling his/her life.

0_____10

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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.

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

Patient Name(Please Print):_____Date:_____

Signature of Patient or Guardian:_____

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

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.

Patient Name (print):

_____Date:_____

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_____
Signature of Witness_____Date_____