Pelvic Wellness CENTER

Restoring function through physical therapy

1034 Lawrence St
Eugene, OR 97401
541-515-6215

1644 Liberty SE
Salem, OR 97302
503-983-8811

Patient History

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

Email Address_____
Marital Status:_____
Occupation: _____ Average Hours Worked/Week_____
Do you: Smoke? Y / N Consume Alcohol? Y / N Use Illicit Drugs? Y / N Consume Caffeine? Y/N

General Health: Excellent Good Average Fair Poor
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_____

1. Describe the current problem that brought you here? _____
_____
2. On a scale of 1-10, how severe is your problem? (10 = most severe) _____
3. When did your problem first begin? _____
4. Was your first episode of the problem related to a specific incident? Yes/No
Please describe _____
_____
5. Have your symptoms changed over time? If yes, describe _____
_____
6. If pain is a concern, rate your pain on a 0-10 scale (10 being the worst)
When the pain is lowest: ___When pain is highest: ___
Describe the nature of your pain (i.e. constant burning, intermittent ache) _____
_____

7. Describe previous treatment/exercises _____
_____

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)
___ With lifting/bending
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity _____
___ With cough/sneeze/straining
___ With laughing/yelling
___ With cold weather
___ With triggers -running water/key in door
___ With nervousness/anxiety
___ With Strong Bladder or Bowel Urge
___OTHER, please list_____

_____

9. What relieves your symptoms?

_____
_____

10. How has your lifestyle/quality of life been changed?
Please Explain Below:
Social activities (exclude physical activities)_____
Diet/Fluid intake_____
Physical activity_____
Work_____
Other_____

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	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	HIV/AIDS
Smoking History	Bone Fracture	Sexually Transmitted
Vision/Eye Problems	Sports Injuries	Infection
Hearing Loss/Problems	TMJ / Neck Pain	Physical or Sexual abuse

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_____

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

If yes above, describe including dates_____
_____
_____

Page 3 Symptoms **Name** _____

15. Ob/Gyn History (Females Only)

Y/N Vaginal dryness	Y/N Childbirth vaginal deliveries #___
Y/N Painful periods	Y/N Episiotomy #
Y/N Painful vaginal penetration	Y/N C-Section #
Y/N Pelvic Pain	Y/N Difficult childbirth #
Y/N Vulvar/Vaginal Skin Condition	Y/N Prolapse or organ falling out
Y/N Menopause - when?	
Y/N Hysterectomy, date_____	

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 completely	Y/N Trouble Feeling Bladder Urge
Y/N Difficulty stopping the urine stream	Y/N Current Laxative Use
Y/N Straining or pushing to empty bladder	Y/N Trouble feeling bowel/urge/fullness
Y/N Dribbling after urination	Y/N Constipation/straining
Y/N Constant urine leakage	Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections	

Y/N Other/describe _____

Frequency of urination: ____less than 8 times/day ____more than 8 times/day

How many times do you urinate at night (during sleeping hours)? ____

When you have an urge to urinate, how long can you delay before you have to go to the toilet?

_____

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 water intake __less than 6 cups (8 oz)/day __more than 6 cups/day

Other Beverages, list _____

Of this total how many glasses are caffeinated?__cups (8 oz)/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_____

Page 4 Pelvic Symptom Questionnaire Name_____

Skip to question #18 if no leakage/incontinence

Bladder leakage - number of episodes	Bowel leakage - number of episodes
Episodes ___ per day	Episodes ___ per day
Episodes ___ per week	Episodes ___ per week
Episodes ___ per month	Episodes ___ per month
___ Only with physical exertion or activity	___ Only with exertion or activity
Describe_____	Describe_____
___Only with strong urge	___Only with strong urge

On average, how much urine do you leak? How much stool do you lose?

__ No leakage	__ No leakage
__ Just a few drops	__ Stool staining
__ Wets underwear	__ Small amount in underwear
__ Wets outerwear	__ Complete emptying
__ Wets the floor	

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?
_____
_____

For therapists use:

Post:
ROM:

S/E/C

Visual:

Px:

Other Tests:

Rx:

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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. 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.

Release of medical records:

I authorize the release of my medical records to my physicians/primary care provider or insurance company.

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. I hereby request and consent to the evaluation and treatment to be provided by the therapist _____

Date_____ Patient Name: _____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

Witness Signature_____

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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. 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.

"OUT OF NETWORK"

If Pelvic Wellness Center is "out of network" according to your insurance plan, you will be billed as per your "out of network" benefits, if you choose to have us bill for the services rendered.

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. Co-payments are due at the time of service. A $125.00 payment toward your deductable will be due at the time of your first visit, effective for new patients seen after January 1, 2014. If your deductable amount is less than $125.00, than you will be responsible for that amount to be paid at your first visit. You will also be responsible for a $50.00 fee to be paid at next scheduled appointment should you cancel without 24 hr notice, or "no show" an appointment (please see cancellation policy).

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. All payments received after 90 days from this date will be considered delinquent, and a late fee of 1.5% per month (18% APR) will be assessed on all unpaid balances. Unpaid balances beyond 120 days may be referred to collections. **We will work with you to avoid sending your account to collections. If there is a hardship, please ask us to set up a payment plan.**

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 therapists.

If you must cancel, we request that you provide 24 hour notice. If you cancel less than 24 hours in advance, you will be responsible for a cancellation fee of $50. This includes "no show" appointments. Your therapist may use their discretion if the reason for your cancellation is unavoidable. **This payment is not billable to insurance**. If you have more than 2 "no show" occurrences without contacting our office, all future appointments will be cancelled.

COLLECTIONS

If necessary, we will send your account to collections. You will be responsible for an additional 20% to your outstanding balance to cover fees associated with the collections process. This percentage will be increased to 30% if taken to small claims.

CASH PAYMENT DISCOUNT

Cash payment arrangements are for those patients without insurance coverage or are considered "out of network" and choose not to have Pelvic Wellness Center bill insurance directly for services rendered. Our fee for cash visit is $150.00 for Initial Physical Therapy Evaluation to be paid in full at the time of the appointment. Follow up visits will be $125.00 per visit for 45 min to one hour session.

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 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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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_____Date_____

Signature of Witness_____Date_____