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Welcome to Pelvic Therapy Specialists, PC

So that your first visit and evaluation may be as efficient and productive as possible, following are some forms that we ask you to fill out before your appointment.

Completed forms allow for more treatment time in your first visit and less time spent on administrative items. More importantly, patients typically remember additional pertinent facts concerning their medical history when pre-evaluation forms are completed in the comfort of their homes.

Following you will find:

Pre-Evaluation Questionnaire
Confidentiality and Financial Policy
Informed Consent for Treatment of Pelvic Floor
Cancellation and No Show Policy
HIPPA Privacy Notice

Thank you for choosing Pelvic Therapy Specialists for your physical therapy care.

We look forward to working with you.

Sincerely,

Sandra Shevlin, DPT

777 29th Street, Suite 102, Boulder, CO 80303
Email info@pelvictherapy.com
Phone 303.601.7495
Fax 888.433.8309

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PRE-EVALUATION QUESTIONNAIRE: FEMALE VERSION

Please remember to bring in completed forms to your first appointment.

Name _____

Address _____ City/State/Zip _____

Home Ph _____ Cell Ph_____ Email _____

Age _____ Date of Birth _____ Employer Name _____

Emergency Contact Name and Ph Number _____

Referring Provider Name:_____

Address _____ City/State/Zip _____

Work Ph_____ Fax _____

If no referring provider, how did you hear about us? Facebook / Google / Yahoo / Friend-Family / Workshop-Class / Other: (please state) _____

Primary Care Provider Name:_____

Address _____ City/State/Zip _____

Work Ph_____ Fax _____

Reason for your visit: _____

_____

Goals of therapy:

_____

_____

Please List your Primary Complaints:

1.

2.

3.

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Discomfort Feedback

If you have pain or discomfort anywhere in the body, even if you don't think it is related, please complete the questions below:

Rate your pain area on a scale of 0 -10 when the pain is at its Min #__/10 and at its Max __/10. (0 = no pain: 10 worst pain you can imagine).

Worst pain area: _____ Min__/10 Max__ /10

Pain is: dull / sharp / burning / cramping / pressure/ electrical and is it constant / intermittent

Pain began: gradually / suddenly on / around (date): _____ due to (if known) _____
Pain is localized / radiating

Pain began: in the _____ and spread to _____

Since onset pain has: increased / decreased / stayed the same in severity / frequency / duration

Pain increases with: lifting / sitting / standing / walking / bending / climbing / driving / sexual intercourse / reaching / housekeeping / social activities / work activities / weather changes / sneezing / deep breathing / coughing / Other: _____

Pain decreases with: rest / ice / heat / postural or positional changes / other _____

Next worst pain area: _____ Min__/10 Max__ /10

Pain is: dull / sharp / burning / cramping / pressure/ electrical and is it constant / intermittent

Pain began: gradually / suddenly on / around (date): _____ due to (if known) _____
Pain is localized / radiating

Pain began: in the _____ and spread to _____

Since onset pain has: increased / decreased / stayed the same in severity / frequency / duration

Pain increases with: lifting / sitting / standing / walking / bending / climbing / driving / sexual intercourse / reaching / housekeeping / social activities / work activities / weather changes / sneezing / deep breathing / coughing / Other: _____

Pain decreases with: rest / ice / heat / postural or positional changes / other _____

Please list any additional areas of pain: _____

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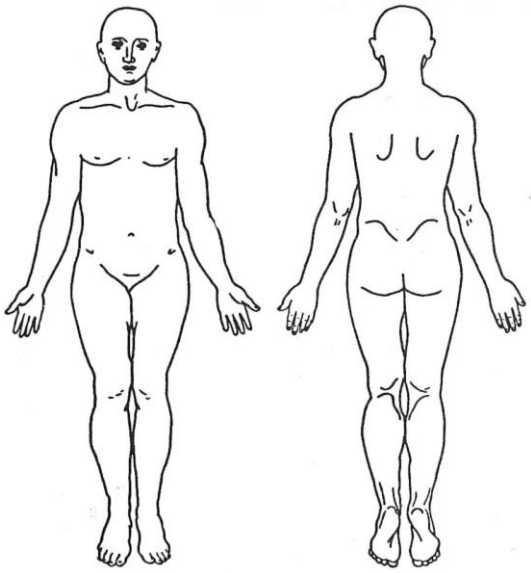
Please mark diagram below to show the therapist where you experience your symptoms



Are you experiencing any weakness? Yes / No Where? _____

Are you experiencing any numbness? Yes / No Where? _____

Are you experiencing any tingling or pins / needles sensation? Yes / No Where? _____

Have you had any **sudden** weight loss or sudden weight gain? Yes / No Explain _____

_____

Medical History (please circle letters for: Never, Once, Sometimes, Frequent, Currently)

Bladder infection N – O – S – F – C	Menopause Yes / No	Arthritis N – O – S – F – C
Vaginal infection N – O – S – F – C	Constipation N – O – S – F – C	Neurological disorder N – O – S – F – C
Kidney infection N – O – S – F – C	Difficulty sitting N – O – S – F – C	COPD N – O – S – F – C
Urinary incontinence N – O – S – F – C	High blood pressure N – O – S – F – C	Fibromyalgia N – O – S – F – C
Fecal incontinence N – O – S – F – C	Hemorrhoids N – O – S – F – C	Chronic fatigue N – O – S – F – C
Pelvic/abdominal adhesions N – O – S – F – C	Diabetes N – O – S – F – C	Allergies/sinusitis N – O – S – F – C
Pelvic pain N – O – S – F – C	Cancer N – O – S – F – C	Emphysema/bronchitis N – O – S – F – C

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Abdominal pain N – O – S – F – C	Cardiovascular disease N – O – S – F – C	Depression N – O – S – F – C
Hormonal problems N – O – S – F – C	Thyroid problems N – O – S – F – C	Headaches N – O – S – F – C
Endometriosis Yes / No	Liver disorder N – O – S – F – C	Anxiety N – O – S – F – C
Pelvic inflam. Disesase N – O – S – F – C	Interstitial cystitis N – O – S – F – C	Digestive problems N – O – S – F – C
Prolapse (if known) N – O – S – F – C	Cysts N – O – S – F – C	Multiple sclerosis N – O – S – F – C
Painful intercourse N – O – S – F – C	Fibroids N – O – S – F – C	Sexually transmitted disease N – O – S – F – C
Other:		

History of surgeries and traumas, *with* **approximate dates:**

Appendectomy	Hysterectomy (total/partial)	Pacemaker
Laparoscopy	C-section	Radiation therapy
Gall bladder removal	Episiotomy	Falls on tailbone, back, hip
Surgery/biopsy to cervix	Abortion	Hit on head/back
Bladder repair	D & C	Physical or sexual abuse
Abdominal surgery	Low back/hip injury	Pelvic surgery
Pins/plates/screws inserted	Other:	

Social History

Please describe your usual **mode, duration and frequency of exercise**:

_____

Do you drink alcohol? Yes/ No How many drinks do you have a day / week? _____

Do you smoke cigarettes? Yes / No Number of cigarettes / packs you smoke daily? _____

Are you able to work? Yes / No / Part-time (Please circle)

If yes, what do you do for work?_____

Menstruation History (if applicable)

Frequency of your periods (in days) _____

How long does your period last (in days) _____

Do you ever experience pain with your periods? Yes / No

Do you need medication? Yes / No

Bladder History (if applicable)

How much clear liquids do you drink per day (oz)? _____ Caffeine (oz)?_____

Alcohol (oz)?_____ Other? (please list type)_____

Do you leak urine when you cough, sneeze, laugh, jump, run, lift, etc? _____

Do you ever have such an uncomfortably strong need to urinate that if you don't reach the toilet you will leak? _____

If "yes" do you ever leak before you reach the toilet? _____

How often do you need to void your bladder (please give me a range)? _____

How many times do you void (urinate) during the night, after going to bed?_____

Have you wet the bed in the past year? _____

Do you develop an urgent need to urinate when nervous, under stress, or in a hurry? _____

Do you ever leak urine during or after sexual intercourse? _____

Do you find it necessary to wear a pad because of your leaking? _____

How often do you leak urine? _____

Have you had bladder, urine, or kidney infections?_____

Are you troubled by pain or discomfort when you urinate? _____

Have you had blood in your urine recently? _____

Do you find it hard to begin urinating? _____

Do you have a slow urine stream? _____

Do you have to strain to pass your urine? _____

After you urinate, do you have dribbling, or a feeling your bladder is still full? _____

Do you/have you ever experienced a dragging or "falling out" sensation in the perineal or pelvic floor area? _____

Do you empty your bladder frequently, before you experience the desire to pass urine just so you can stay dry? _____

Circle type of protection worn and how many/day? :

No protection Pantishields Mini Pad

Maxi Pad Diaper / Serenity

Position or activity with leakage:

Lying Down Sitting Standing

Sexual Activity Changing Positions (sit to stand, etc)

How long can you delay the need to urinate?

1+ hours ½ hour 15 minutes

< 10 minutes 1-2 minutes Not at all

Activity that causes urine loss:

Vigorous activity Moderate activity Light Activity No activity

Date of last internal exam/check up: _____

Bowel History (if applicable)

Do you ever leak feces? _____

Do you strain during bowel movements? _____

Do you frequently feel constipated? _____

Do you have any pain or discomfort with bowel movements? _____

Do you feel you can empty your bowels completely? _____

How frequent do you have a bowel movement? _____

Do you ever experience a strong sensation to have a bowel movement? _____

Please circle the most common stool consistency:

Liquid Soft Firm Pellets

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Pregnancy/Birth History (if applicable)

Are you pregnant now? Yes / No / Maybe If yes, how far along are you? _____

Have you ever had or are you currently experiencing pregnancy related complications?

_____

Number of pregnancies _____ Number of deliveries _____

Date of birth _____ Child Weight _____ Date of birth _____ Child Weight _____

Date of birth _____ Child Weight _____ Date of birth _____ Child Weight _____

Diagnostic tests completed relevant to your symptoms and/or your spine/hip/pelvic region: Please list with approximate dates. If you have a copy of the report, please bring that with you._____

_____

_____

_____

List any **medication allergies**: _____

Medication and Supplement History

List medications, nutritional supplements, and over the counter drugs you are currently on:

_____

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INSURANCE WAIVER FORM FOR CASH PAY PATIENTS

I have opted to not to use my out of network health insurance benefits (if available) to obtain a discounted cash pay rate.

I waive the ability to submit claims and bills retroactively to my health insurance company for physical therapy services rendered by Pelvic Therapy Specialists, PC.

In order to process payments efficiently, we will request a copy of your Credit Card at your first visit. Information will be kept secure in accordance with credit card industry regulations.

_____
Patient Name

_____ _____
Patient or Guardian Signature Date

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INFORMED CONSENT FOR ASSESSMENT OF THE PELVIC FLOOR AND GENERALIZED EVALUATION AND TREATMENT

I understand that with referral to physical therapy for a pelvic floor dysfunction and/or biofeedback, it may be beneficial for my therapist to perform a *muscle assessment of the pelvic floor*. Palpation of these muscles is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain, urinary incontinence, dyspareunia (pain with intercourse), pain from episiotomy or scarring, vulvodynia, vestibulitis or other similar diagnoses.

I understand that the benefits of the vaginal/rectal assessment will be explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will notify my physical therapist and the procedure will be discontinued and alternatives will be discussed with me.

Treatment procedures for pelvic floor can include biofeedback, electrical stimulation, and use of vaginal weights and/or manual techniques such as massage or soft tissue work.

The therapist will explain all procedures to be used in my treatment, and I may choose not to participate with all or part of the treatment plan.

Based on the information I have received from the therapist, I voluntarily agree to the standard assessment and treatment plans for my condition.

_____ _____

Patient or Guardian Signature Date

If you are pregnant, have infections of any kind, have vaginal dryness, are less then 6 weeks post partum or post surgery, have severe pelvic pain, sensitivity to KY jelly, vaginal creams or vinyl gloves, please inform the therapist prior to the pelvic floor assessment.

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CANCELLATION AND NO-SHOW POLICY

We are committed to exceptional patient service and clinical care to expedite the healing and recovery process. To accomplish this, it is extremely important that you attend each of your scheduled appointments.

- **Scheduling** is based on a first come, first served basis. It is advisable for you to schedule your appointments in four to six week intervals (if needed) to ensure treatment continuity, as schedules are **commonly booked** for the immediate two weeks.

- In the event that you need to cancel an appointment, **we request at least 24 business hours notice**. Cancellation less than 24 hours can mean that we may not be able to schedule another patient who may be in need of our services.

- In the event of a late cancellation or "no-show," **your account will be assessed a $60 cancellation fee.** This charge will **not be covered by insurance** but will have to be paid by you personally**.** By signing below you **authorize permission for Pelvic Therapy Specialists to run your credit card** at the time.

- We understand that emergencies do occur – late cancellation due to severe weather, illness and family emergency is excluded from this policy. For women, internal treatment while having a period is common. Additionally, we may be able to work on secondary areas that may be a part of your pain and/or symptoms.

- **Arriving on time for your appointment is critical** to the optimal delivery of care. Chronic late arrivals are disruptive to the successful implementation of your patient care plan. Appointment times will still end at the scheduled time regardless of what time you arrive.

I understand the terms of this form. I agree to be financially responsible to pay for charges incurred from cancellations made less than 24 hours or no shows. I authorize Pelvic Therapy Specialists, PC to charge my credit card in the event of a late cancellation or no show.

_____ _____

Patient or Guardian Signature Date

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HIPAA PRIVACY NOTICE

If you have questions and/or would like additional information regarding the uses and disclosures of your health information, you may contact our Privacy Officer at:

Pelvic Therapy Specialists, PC
c/o Sandra Shevlin, DPT
777 29th St, Suite 102
Boulder, CO 80303
Ph 303-601-7495

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201. Complaints filed directly with the secretary must be made in writing, name us, describe the acts or omissions in violation of the privacy rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted to us must be in writing and to the attention of our Privacy Officer. There will not be retaliation for filing a complaint.

By signing below, I hereby acknowledge receipt of this privacy notice.

_____
Printed Name of Patient

_____ _____
Patient or Patient's Representative Signature Date

_____
Representative's Relationship to Patient (if applicable)

To be completed by Pelvic Therapy Specialists, PC:

After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s) _____
_____

_____ _____
Pelvic Therapy Specialists Representative Signature *Date*