



## ADULT PATIENT REGISTRATION

### PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)				
ADDRESS		SOCIAL SECURITY NUMBER		DATE OF BIRTH
CITY	STATE	ZIP	EMAIL ADDRESS	
HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	(Circle One)	Female      Male

**\*\*\*If you have received HELP in the HOME** (bathing, aide help, therapy, nurse visit) in the past three months, please **stop** here, and speak to our receptionist before completing the rest of the patient registration.

For Office Use: (Receptionist - For Medicare patients, call (866) 211-5708 and initial if the patient is already receiving care.) \_\_\_\_\_

**How did you hear about us? Check One:** Doctor \_\_\_\_\_ Advertisement/Radio \_\_\_\_\_ Internet \_\_\_\_\_  
 Friend/Relative (who?) \_\_\_\_\_ Employee (who?) \_\_\_\_\_ Other \_\_\_\_\_

### WHO IS FINANCIALLY RESPONSIBLE FOR TREATMENT?

Myself     My Spouse     My Parent(s)     (Other) or Responsible Party \_\_\_\_\_

**Who is your Primary Care Physician?** \_\_\_\_\_ **Which Clinic Referred You?** \_\_\_\_\_

**Who is your Specialty Physician?** \_\_\_\_\_ **Other Physician:** \_\_\_\_\_

### INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:	SECONDARY INSURANCE COMPANY:
POLICY NUMBER:	POLICY NUMBER:

### POLICY HOLDER'S INFORMATION

NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
ADDRESS (if different from above)		DATE OF BIRTH
CITY	STATE	ZIP
HOME PHONE (if different from above)		
<b>IS THE POLICY HOLDER CURRENTLY EMPLOYED BY THE EMPLOYER PROVIDING INSURANCE?</b> YES NO N/A <b>ARE YOU OR THE PATIENT ON MEDICAL LEAVE?</b> YES NO N/A <b>EMPLOYER NAME:</b> _____ <b>EMPLOYER PHONE NUMBER:</b> _____		

### EMERGENCY CONTACT (NOT living with you)

NAME (Last, First, Middle Initial)				RELATIONSHIP TO PATIENT
ADDRESS	CITY	STATE	ZIP	PHONE #
<b>Workers' Comp On-the-job Injury?</b> <input type="checkbox"/> esY <input type="checkbox"/> No			Date of injury:	
Employer Name, Contact Person & Phone Number:				

## Pelvic Floor Patient History

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ On disability or leave? \_\_\_\_\_

Activity Restrictions? (military please attach copy of most recent physical profile restrictions): \_\_\_\_\_

Educational Level: (circle latest completed)      High School      College      Graduate School

Hobbies: \_\_\_\_\_ # of family members living with you: \_\_\_\_\_

Is English your primary language? Yes/No      If no, what language is? \_\_\_\_\_

1. Circle below or describe the current problem that brought you here: \_\_\_\_\_

Leakage      Urgency      Frequency      Pelvic Pain      Prolapse      Constipation      Sexual Dysfunction

2. When did your problem first begin? \_\_\_\_\_

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 the problem: \_\_\_\_\_ staying the same      \_\_\_\_\_ getting worse      \_\_\_\_\_ getting better

5. If pain is present, rate pain on a 0-10 scale 10 being the worst. \_\_\_\_\_ Describe the nature of the pain (i.e. constant burning, intermittent ache) \_\_\_\_\_

6. Describe previous treatment/exercises: \_\_\_\_\_

7. Activities/events that cause or aggravate your symptoms: *(Check/circle all that apply)*

\_\_\_ Sitting greater than \_\_\_\_\_ minutes      \_\_\_ With cough/sneeze/straining

\_\_\_ Walking greater than \_\_\_\_\_ minutes      \_\_\_ With laughing/yelling

\_\_\_ Standing greater than \_\_\_\_\_ minutes      \_\_\_ With lifting/bending

\_\_\_ Changing positions (ie. - sit to stand)      \_\_\_ With cold weather

\_\_\_ Light activity (light housework)      \_\_\_ With triggers i.e. /key in door

\_\_\_ Vigorous activity/exercise (run/weight lift/jump)      \_\_\_ With nervousness/anxiety

\_\_\_ Sexual activity      \_\_\_ No activity affects the problem

\_\_\_ Other, please list \_\_\_\_\_

8. What relieves your symptoms? \_\_\_\_\_

9. 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: \_\_\_\_\_

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

11. Circle below or describe your treatment goals/concerns? \_\_\_\_\_

Lessen pain      Increase muscle strength/tone      Improve bladder control      Improve Fitness

**Since the onset of your current symptoms, have you had?**

Y/N      Dizziness or fainting      Y/N      Night pain/sweats

Y/N      Change in bowel or bladder functions      Y/N      Malaise (unexplained tiredness)

Y/N      Other - Describe: \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_ Tests performed \_\_\_\_\_

**General Health (please circle):**      Excellent      Good      Average      Fair      Poor**Activity/Exercise (please circle):**      None      1-2 days/week      3-4 days/week      5+ days/week

Describe \_\_\_\_\_

**Mental Health (please circle) :** Current level of stress    High\_\_\_ Med\_\_\_ Low\_\_\_ Current psych therapy? Y/N**Check all the words that apply to how you feel these days:**

\_\_\_ Happy \_\_\_ Calm \_\_\_ Unmotivated \_\_\_ Stressed \_\_\_ Sad \_\_\_ Overwhelmed \_\_\_ Tired \_\_\_ Afraid \_\_\_ Lonely \_\_\_ Weak

\_\_\_ Energetic \_\_\_ Lethargic \_\_\_ Content \_\_\_ Optimistic \_\_\_ Overworked \_\_\_ Flabby \_\_\_ Strong \_\_\_ Unrested \_\_\_ Other: \_\_\_\_\_

**I prefer to learn by:**

\_\_\_ Listening (discussion, lecture, CD's)

\_\_\_ Doing (demonstration, practicing skill)

\_\_\_ Seeing (reading, DVD's, displays, slides)

\_\_\_ Don't know

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

Allergies-list below

Osteoporosis

Acid Reflux /Belching

Ankle swelling

Head Injury

Latex sensitivity

Low back pain

Chronic Fatigue Syndrome

Headaches

Sacroiliac/Tailbone pain

Fibromyalgia

Pelvic pain

Childhood bladder problems

Stress fracture

Irritable Bowel Syndrome

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/problems

TMJ/ neck pain

Other – Describe: \_\_\_\_\_

**What medications are you currently taking?** \_\_\_\_\_**Surgical /Procedure History**

Y/N Surgery for your back/spine

Y/N Surgery for female organs

Y/N Surgery for bladder/prostate

Y/N Surgery for abdominal organs

Y/N Surgery for your brain

Other/describe \_\_\_\_\_

Y/N Surgery for your bones/joints

\_\_\_\_\_

**Ob/Gyn History (females only)**

#Pregnancies: \_\_\_\_\_

Y/N Prolapse or organ falling out

Y/N Pelvic/genital pain \_\_\_\_\_

# Live Births: \_\_\_\_\_

Y/N Currently pregnant

Other – Describe: \_\_\_\_\_

Y/N Vaginal childbirth # \_\_\_\_\_

Y/N Vaginal dryness

Y/N Episiotomy # \_\_\_\_\_

Y/N Painful periods

Y/N C-Section # \_\_\_\_\_

Y/N Menopause - when? \_\_\_\_\_

Y/N Difficult childbirth # \_\_\_\_\_

Y/N Painful vaginal penetration

**Males only**

Y/N Prostate disorders

Y/N Erectile dysfunction

Y/N Shy bladder

Y/N Painful ejaculation

Y/N Pelvic/genital pain – Location: \_\_\_\_\_

Y/N Other – Describe: \_\_\_\_\_

## Pelvic Symptom Questionnaire

### Bladder / Bowel Habits / Symptoms

- |   |   |
|---|---|
| Y/N Trouble initiating urine stream       | Y/N Blood in stool/feces                  |
| Y/N Urinary intermittent /slow stream     | Y/N Painful bowel movements (BM)          |
| Y/N Strain or push to empty bladder       | Y/N Trouble feeling bowel urge/fullness   |
| Y/N Difficulty stopping the urine stream  | Y/N Seepage/loss of BM without awareness  |
| Y/N Trouble emptying bladder completely   | Y/N Trouble controlling bowel urge        |
| Y/N Blood in urine                        | Y/N Trouble holding back gas/feces        |
| Y/N Dribbling after urination             | Y/N Trouble emptying bowel completely     |
| Y/N Constant urine leakage                | Y/N Need to support/touch to complete BM  |
| Y/N Trouble feeling bladder urge/fullness | Y/N Staining of underwear after BM        |
| Y/N Recurrent bladder infections          | Y/N Constipation/straining _____% of time |
| Y/N Painful urination                     | Y/N Current laxative use -type _____      |
| Y/N Other/describe _____                  |   |

Describe typical position for bladder/bowel emptying: \_\_\_\_\_

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 is:      \_\_\_ Times Per Day      \_\_\_ Times Per Week      Or \_\_\_\_\_
5. The bowel movements typically are (*use Bristol Stool Scale available at <http://www.integrityrehab.net/patient-info.html>*):  
    Watery \_\_\_ Loose \_\_\_ Formed \_\_\_ Pellets \_\_\_ Other \_\_\_\_\_
6. 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
7. If constipation is present, describe your management techniques: \_\_\_\_\_
8. 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.
9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:  
     \_\_\_ None present  
     \_\_\_ Times per month (specify if related to activity or your menstrual period)  
     \_\_\_ With standing for \_\_\_\_\_ minutes or \_\_\_\_\_ hours.  
     \_\_\_ With exertion or straining  
     \_\_\_ Other \_\_\_\_\_

#### 10a. Bladder Leakage - Number of Episodes

- \_\_\_ No leakage  
 \_\_\_ Times per day  
 \_\_\_ Times per week  
 \_\_\_ Times per month  
 \_\_\_ Only with physical exertion/cough

#### 10b. Bowel Leakage - Number of Episodes

- \_\_\_ No leakage  
 \_\_\_ Times per day  
 \_\_\_ Times per week  
 \_\_\_ Times per month  
 \_\_\_ Only with exertion/strong urge

#### 11a. On average, how much urine do you leak?

- \_\_\_ No urine leakage      \_\_\_ Wets outerwear  
 \_\_\_ Just a few drops      \_\_\_ Wets the floor  
 \_\_\_ Wets underwear

#### 11b. How much stool do you lose?

- \_\_\_ No stool leakage      \_\_\_ Complete emptying  
 \_\_\_ Stool staining      \_\_\_ Other: \_\_\_\_\_  
 \_\_\_ Small amount in  
     underwear      \_\_\_\_\_

#### 12. What form of leakage protection do you wear? (Please complete only one)

- \_\_\_ None      \_\_\_ Moderate protection (absorbent product, maxi pad)  
 \_\_\_ Minimal protection (tissue paper / paper towel / pantishields)      \_\_\_ Maximum protection (specialty product/diaper)

On average, how many pad/protection changes are required in 24 hours? \_\_\_\_\_ # of pads

## INFORMED CONSENT FOR ASSESSMENT OF PELVIC FLOOR DYSFUNCTIONS

I understand that if I am referred to physical therapy for pelvic floor dysfunction, it may be beneficial for my therapist to perform a muscle assessment of the pelvic floor, initially and periodically to assess muscle strength, length, range of motion and scar mobility. Palpation of these muscles is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain syndromes, urinary incontinence, fecal incontinence, dyspareunia or pain with intercourse, erectile dysfunction, pain from an episiotomy or scarring, vulvodynia, vestibulitis or other similar complications. Evaluation of my condition may include observation, soft tissue mobilization, use of vaginal cones, vaginal or rectal sensors for biofeedback and/or electrical stimulation.

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 inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

Treatment procedures for pelvic floor dysfunctions include, without limitation, education, exercise, stimulation, ultrasound, use of vaginal weights, and several manual techniques including massage, joint and soft tissue mobilization. The therapist will explain all these treatment procedures to me and I may choose to not participate with all or part of the treatment plan.

**\*\*If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks postpartum or post surgery, have severe pelvic pain, sensitivity to KY jelly, vaginal creams or latex, please inform the therapist prior to the pelvic floor assessment.**

### CONDITIONS & CONSENT FOR PHYSICAL THERAPY

1. **COOPERATION WITH TREATMENT:** *I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstance that prevent me from attending therapy. I understand that I may be discharged from physical therapy if I do not keep three (3) appointments without calling to cancel or reschedule. I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss it with my therapist.*
2. **NO WARRANTY:** *The physical therapy department does not promise a cure for my condition. The staff will share with me the available statistics and studies regarding results of physical therapy treatment for my condition. They will discuss all treatment options with me.*
3. **INFORMED CONSENT TO TREATMENT:** *The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you. The clinic provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition. The evaluation may consist of an internal assessment of your pelvic floor muscles.*

**Potential Risks:** You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is temporary and will probably subside in 24 hours.

**Potential Benefits:** Benefits include an improvement in your symptoms and an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. You will have greater knowledge on managing your condition and the resources available to you.

**Alternatives:** All physical therapy treatment options available for your conditions will be explained to you. You may inquire on the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your physician.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment. Based on the information I have received from the therapist, I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

\_\_\_\_\_  
Patient's Signature and Date

\_\_\_\_\_  
(For Minors) Patient's Legal Representative/Guardian/Parent and Date

\_\_\_\_\_  
Therapist's Signature/Date

\_\_\_\_\_  
Relationship to Patient