General Intake Form

PATIENT INFORMATION & MEDICAL HISTORY

(Federal regulations require a medical history must be included in all patient's medical records in this office)

Date________ Referring Physician _________________________SS#______________________

Patient's Name_________________________Age______Birth Date_________Pronouns______

Address____City_______________Zip__________

Phone_________________Mobile#______________Email________________________________

Employer____________________Work Phone_____________Occupation________________

Employer's Address____________________________City_________________Zip_________

Do you now have or have you had any of the following:

Y/N Diabetes Y/N Headaches Y/N Current Pregnancy
Y/N High Blood Pressure Y/N Kidney Problems Y/N Substance Abuse
Y/N Heart Disease Y/N Anxiety Disorder Y/N Hernia (ventral,inguinal,etc.)
Y/N Heart Attack Y/N Allergies to Heat/Ice Y/N Seizures
Y/N Pacemaker Y/N Other Allergies Y/N Metal Implants
Y/N Cancer Y/N Bowel/Bladder Problems Y/N Sexual or Physical Abuse
Y/N Stroke/Head Injury Y/N Sexually Transmitted Illness Y/N HIV/AIDS
Y/N Neurologic Disorder Y/N Smoking Habit Y/N Broken Bones/Joint Pain
Y/N Work Comp Injury Y/N Latex Sensitivity Y/N Food Intolerances/IBS
Y/N Spine Surgery Y/N Bladder Surgery/Sling/Mesh Y/N Bowel Surgery
Y/N Brain Surgery Y/N Prostate Surgery Y/N Constipation/Diarrhea
Y/N Abdominal Surgery Y/N Hysterectomy(vaginal/abd/lap) Y/N Bladder Infections
Y/N Depression Y/N Recent Weight Loss Y/N Shortness of Breath
Y/N Easy Bruising Y/N Chest Pain Y/N Recent Trauma/Fall/MVA
Y/N Balance Disturbance Y/N Morning Stiffness Y/N Changes to Nail Beds
Y/N Fever/Chills Y/N High Cholesterol Y/N Night Pain/Sleep Disorder

If **yes** on any above, please explain and give approximate dates and pertinent details and please list any other diagnosis and/or orthopedic injuries, past or present.

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OB-GYN Hx:

Y/N Prior Pregnancy#____Y/N Vaginal Deliveries #/Dates:___________ Y/N Episiotomy/Tear
Y/N Miscarriage Y/N Cesarean Births #/Dates:____________ Y/N Difficult Births: #
Y/N Known Prolapse Y/N Fibroids/Endometriosis/Cysts Y/N Painful Periods
Y/N Menopause-age:_____Y/N Painful Vaginal Penetration (superficial/deep) Y/N Pelvic Pain
Y/N Hormone Therapy Y/N Oral Contraceptives Y/N IUD in place
Y/N Menstrual Irregularities Y/N Hot Flashes/Night Sweats Y/N Mood Swings

Other:____

Are you presently taking medication? Yes/No; If yes, please list what medications and for what conditions:____

Have you had previous physical therapy or chiropractics for your present condition or for any other condition this year? Yes/No: If yes, state where, approximate visits, and for what condition.

____

____

Have you had any diagnostic tests for this condition (i.e. x--ray, MRI, CT scan, Urodynamics/ VCUG/Ultrasound, Colonoscopy/etc? If yes, then where? Bring copy of reports for review.

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____

Reason for visit today:

____

____

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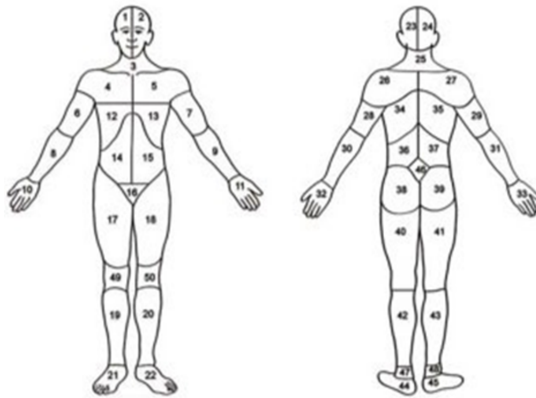
During the past month have you been feeling down, depressed or hopeless? Y/N
During the past month have you been bothered by having little or no interest in pleasure? Y/N?
Is this something with which you would like help? Y/N
Do you know what the cause may be?______________________How long present?_______
Do you currently have a counselor/therapist available to you? Y/N

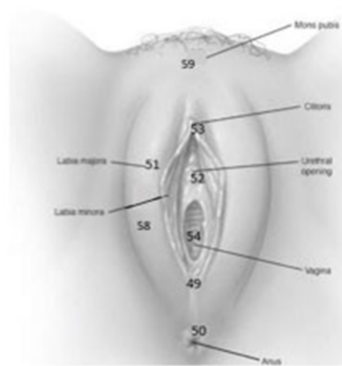
Bowel and Bladder Symptom Questionnaire: (please fill in blanks and circle all that apply)

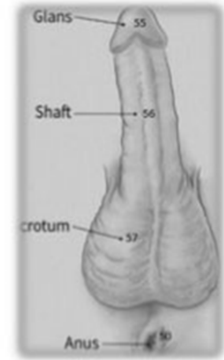
1. Describe your *main problem*: ____
2. When did your bowel or bladder problem *first* begin?_____________________________
3. Was your first incident related to a specific incident? Yes / No
4. Since that time is it: getting worse/getting better/staying the same?
5. *Frequency of urination* during wake hours? ______during sleep hours? ___________
6. When you have the *urge to urinate,* how long can you *delay*? minutes/hours/not at all
7. Usual *amount of urine passed* is small/medium/large/varies.
8. *Frequency of bowel movements* _____per day____per week, or other?______________
9. If 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.
10. Is there *blood i*n your urine or stool? Yes / No; Please describe: ______________________
11. *Average fluid intake*(one glass is 8oz or 1 cup)______glasses per day; ___ caffiene/irritants.
12. *Bladder Leakage:* ________xs per day, week, month, or only with exertion/cough.
13. On average, *how much do you leak*? None/few drops/wets underwear/outerwear/floor
14. *Bowel Leakage:* _________xs per day, week, month, or only with exertion/cough.
15. How much stool do you lose? none/stool staining/small amount/complete Loss
16. What *form of protection do you* wear? none/minimal liner /moderate/maximum absorbency
17. On average, how many *pad changes* are required in 24 hours?_____________
18. *Activities that cause your symptoms*: strong urge to go/ walking to toilet/ sit to stand or transitions/cough/laugh/sneeze/yell/vigorous activity/run/jump/light activity, sexual activity/ key in the door/hearing running water/dietary irritants/other?_________________________
19. Do you experience any of the following: trouble feeling an urge, hesitant stream, trouble initiating the stream, pain with urination or defecation. Please circle and describe below.

    ____

Please mark where your pain/pressure/discomfort symptoms are with an "X".







Describe your Pain: *(Circle all that apply)*

Aching Throbbing Shooting Sharp Tender Cramping Splitting Unbearable

Numb Stabbing Burning Constant Irritating Heavy Tearing Other____

Rate your pain on a scale of 0 – 10, with 10 being severe enough for hospitalization:_______

What makes your pain worse?: Intercourse / Arousal / Orgasm / Stress / Full meal / Full bladder/ Urination / BM/ Walking / Sitting / Standing / Exercise / Bending/ Lifting/ Twisting/ Time of day / Weather / Contact with clothing / Coughing / Sneezing / Not related to any activity / Other:________

What helps your pain? Meditation / Relaxation / Lying down / Music / Massage / Ice / Heat / Hot Bath / Medication / Laxatives / Enema / Injections / TENS Unit / Bowel Movement / Emptying Bladder / Nothing Changes My Pain/ Other: ____

My symptoms are better in the: morning / evening / with movement / with rest.

Perceived Severity of Bladder Problem: ___ /10 (0 no effect- 10 controls your life)

Perceived Severity of Bowel Problem: ____ /10 (0 no effect-10 controls your life)

Perceived Severity of Heaviness/Pressure: ____/10 (0 none-10 the worst imaginable)

Current Exercise/Leisure/Hobbies: ____

Lifestyle alterations because of your condition: (i.e. work, fluid intake, social)__________________

____

Personal goals for physical therapy: ____

____

Anything else that you want to tell me?____

____

Patient Signature:____

NOTICE OF INFORMATION PRACTICES

It is the duty of the staff at Inner Strength Pelvic Physical Therapy/Women's Health Physical Therapy to protect the privacy of patients' personal health information. Patients must be informed of how their personal health information may be used and should feel free to ask questions regarding such policies or file complaints with the facility's privacy holder.

Sensitive information or data that reveals aspects of a patient's identity or treatment (e.g. address, DOB, SSN, evaluation findings, etc.) may not be released to unauthorized entities without permission from the patient. Patients have the right to review their medical record, submit amendments to their medical record, reverse authorization for release of information, designate individuals that may receive privacy information, and receive notification of any changes to information practices.

Patients' personal health information may be used without authorization for purposes of treatment or billing services, Information may also be used without patient consent in situations required by law or when determined to be beneficial to the public such as research or public health activities. It is not a violation of privacy standards for patients to use a sign in sheet, receive phone messages from a health care provider, or hear their name called out in the waiting room office. It is the goal of the staff at Inner Strength Pelvic Physical Therapy/Women's Health Physical Therapy to use the minimally necessary information during communications when patient consent is not required. This notice remains posted in the office.

Privacy Officer: Brande Moffatt, PT, DPT, PRPC
Inner Strength Pelvic Physical Therapy
Women's Health Physical Therapy

I have read, understood, and had the opportunity to ask any questions about the above information. I consent to having my personal health information used as stated above.

Name	**Signature**	**Date**

I designate the following individuals to have authorization for disclosure of my personal health information pertaining to all that is inherently involved with my course of treatment. I may revoke this authorization at any time.

Name	**Signature**	**Date**

Name	**Signature**	**Date**

Name	**Signature**	**Date**

CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. 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 or bladder functions, sacroiliac conditions, sexual dysfunction, and/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 primarily by observing and/or palpating the perineal region, including the vagina and/or rectum externally and /or internally. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar and nerve mobility and tenderness, as well as the function of the pelvic floor region. **Examination on pediatric patients is limited to external palpation and observation only, and no internal muscle examination is completed.**
Chaperone Policy: I understand that I have the option of bringing a spouse, family member, or friend with me to my visits, if it makes me feel more comfortable having a second person in the room with me. Otherwise, I understand that I can decline this option. If I am under age of 18, I agree to always have my parent/guardian attend my visits with me.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction. Treatment may also include the use of foam rollers and Swiss ball exercises.

Potential Risks: I may experience an increase in my current level of pain or discomfort if any, 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 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 physical therapy 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 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 treatment for my condition and will discuss all treatment options with me before I consent to treatment.
******If you are pregnant, have infections of any kind, have vaginal dryness, are less than 6 weeks post partum or post surgery, have severe pelvic pain, sensitivity to vaginal lubricants or latex, please inform the therapist prior to pelvic floor assessment.******

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. I understand that I may withdraw at any time.
Patient Name/Signature: ________________________________/____
Guardian Signature:____ Date:____________________________________

Notice to All patients:

Please keep in mind that your appointment time is reserved for you and prevents Brande from seeing anyone else. Due to the type of therapy that Brande provides, she only sees one patient at a time, and she does not utilize any Physical Therapy Assistants/Aides or ancillary staff. You will receive one-on-one care for the duration of your visits.

As a result, No Shows or Cancellations with less than **48 hours notice** have a significant impact on her Practice. As appointments are one hour in length, last minute cancellations lead to a full hour of idle time in our office.

By signing below, I agree to compensate Brande Moffatt, PT, DPT, PRPC, **$75.00** for any appointment to which **I do not show,** or **cancel with less than 48 hours notice.** This fee will be billed to your account and will not be covered by your insurance company. We understand that emergencies happen, but please do your best to comply with this policy. Late arrivals will still be charged the fee for the entire visit. We provide you with a print out of your scheduled appointments when you start physical therapy. Please keep in mind that we do not call to remind you of your appointments**.**

Please be sure to have all intake paperwork completed prior to your first appointment with Brande. This will allow you to maximize your therapy time.

At your first appointment, after your evaluation, Brande will let you know if she believes that sEMG biofeedback or vaginal dialators will be necessary to complete your care. If you should need internal sEMG biofeedback, there is a one time charge of $52.00, payable to the equipment company, to cover the cost of your individual vaginal or rectal sEMG sensor. If you need only external biofeedback, there is a $25.00, 1x equipment charge, for the single use external electrodes. Should you need vaginal dialators for your treatment, Brande will assist you in ordering them, and typically the cost ranges from $46.00 (for 4 dialators) to $84.00 (for 8 dialators) depending on how many sizes you need.

I have read, understand and agree to the above terms:

____ __________________

Patient Signature/Print Name **Date**

PFDI- 20 Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the **last 3 months**.

The PFDI-20 has 20 items and 3 scales of your symptoms.
All items use the following format with a response scale from 0 to 4.

Symptoms Present = YES, scale of bother: 1 = not at all
2 = somewhat
3 = moderately
4 = quite a bit

Symptoms Not Present = NO 0 = not present

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you ...	No	Yes
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal Distress Inventory 8 (CRAD-8):

Do you ...	No	Yes
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary Distress Inventory 6 (UDI-6):

Do you ...	No	Yes
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20:

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PFSI-20 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).