FYZICAL

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Email: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: _____ SSN: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Primary Care Physician/ Family Doctor (s): _____

Are you currently receiving Physical Therapy services? ____No _____Yes, name of company _____

How did you hear about Fyzical? : _____

If Patient is a minor

Responsible party for bill if other than patient: _____ Relationship: _____

Responsible party's address (if other than above): _____

Date of Birth: _____ Social Security #: _____

Consent for Treatment:

I hereby consent to receive care for therapy services by Fyzical. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

Consent to Release Medical Information:

I authorize Fyzical to release any information acquired in connection with my physical therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____

Consent to Obtain Medical Information:

I authorize Fyzical to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's documentation.

Guarantee of Payment:

I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

I hereby certify that I understand these rights as set forth.

Patient/ Responsible Party Signature: _____ **Date:** _____

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Personal Information:

Height ___ ft ___ in Weight _____

Marital Status: □ single □ married □ divorced

Employment Status: □ Employed Full-time □ Employed Part- time □ Unemployed □ Student □ Disabled

□ Not working because of illness

If you are currently employed, what best describes your job: □ Desk work □ Manual Labor

Living Situation: □ Live alone □ Live with spouse/family □ Assisted- living facility

About Your Current Complaint:

Is this complaint auto related? Yes □ No □

Have you fallen in the last 12 months? □ Yes □ No

Are you currently receiving home health or other therapy services? □ Yes □ No

What is the complaint that brought you here? _____

When did this problem begin, or recently become worse? _____

What caused this problem? _____

Does this problem affect your activity choice, tolerance, efficiency or effectiveness? Yes □ No □

If "Yes", what activities? _____

What makes your problem better? _____

Worse?_____

Does this complaint affect your comfort, mood, or ability to sleep? Yes □ No □

What symptoms are you experiencing with this complaint?

□ Swelling □ Loss of motion □Weakness □Loss of balance or coordination □ Numbness □ Tingling

□ Other: _____

How frequent are the symptoms experienced? □ Constant □ Intermittent

How much pain are you experiencing? □ None □ Very Mild □ Mild □ Moderate □ Severe □ Very Severe

What tests have you had for this complaint? □ X-Ray □ CAT Scan □ MRI □ Myelogram □ Bone Scan

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Medical History:

Please check all medical conditions you have, or have had:

□ High blood pressure □ Diabetes □Pacemaker □ Stroke/TIA □ Vertigo □ Asthma □ HIV/AIDS □ Cancer

□ Tumor □ Concussion □ Heart Attack □ Neuropathy □ Epilepsy/Seizures □ Arthritis □ Hearing Loss

□ Pregnancy □ Bowel/ Bladder Problems □ Tobacco use □ Drug or alcohol use

□ Other: _____

Please list surgeries:

_____

_____

_____

_____

Please list all medications you are currently taking:

_____

_____

_____

_____

Please list all allergies:

_____

_____

_____

PTLINK

INFORMED CONSENT FOR PELVIC FLOOR MUSCLE 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 to you. 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 therapists 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. I will have the opportunity to give/revoke my consent at each treatment session.

Treatment may include, but is not limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, external and/or internal soft tissue and/or joint mobilization and educational instruction.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment (as described above). The second person could be a friend, family member, or clinic staff member. Please indicate your preference with your initials:

_____ YES I want a second person present during the pelvic floor muscle evaluation and treatment.
_____ NO I do not want a second person during the pelvic floor muscle evaluation and treatment.
_____ I would like to discuss my options with my physical therapist prior to consenting.

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: may include 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.

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 improvement in my condition. I understand my therapist will share with me her opinions regarding potential results of physical therapy 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 an evaluation or be treated. I hereby request and consent to the evaluation and treatment to be provided.***

Patient Name (please print) _____

Patient Signature _____ Date_____

Witness Signature_____ Date_____

******If you are pregnant, have an infection of any kind, have an IUD or other implants, have a sexually communicable disease, are less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity to lubricant, vaginal creams or latex, please inform the therapist prior to the pelvic floor assessment.***

Pelvic Floor Distress Inventory – PFDI 20

Patient Name: _____ Date: _____

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

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)	No		Yes			
PLEASE PICK ONLY ONE REPSONSE PER QUESTION	0 Never		1 In the past	2 Current	3 Current	4 Current
Do you....	Never		Not now	Some-what	Moder-ately	Quite a bit
1. Usually experience pressure in 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
Subtotal for POPDI-6= Sum or scores / # answered = _____ x 25 = _____						
Colorectal-Anal Distress Inventory – 8 (CRADI-8)	Never		Not now	Some-what	Moder-ately	Quite a bit
1. Feel you need to strain too hard to have a bowel movement?	0		1	2	3	4
2. Feel you have not complete emptied your bowels at the end of a bowel movement?	0		1	2	3	4
3. Usually lose stool beyond your control if your stool is well formed?	0		1	2	3	4
4. Usually lose stool beyond your control if your stool is loose?	0		1	2	3	4
5. Usually lose gas from the rectum beyond your control?	0		1	2	3	4
6. Usually have pain when you pass your stool?	0		1	2	3	4
7. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0		1	2	3	4
8. Does part of your bowel ever pass through the rectum and bulge outside during or aft3er a bowel movement?	0		1	2	3	4
Subtotal for CRADI-8= Sum or scores / # answered = _____ x 25 = _____						
Urinary Distress Inventory 6 (UDI-6)	Never		Not now	Some-what	Moder-ately	Quite a bit
1. Usually experience frequent urination?	0		1	2	3	4
2. Usually experience urine leakage associated with a feeling of urgency, strong sensation of needing to use the bathroom?	0		1	2	3	4
3. Usually experience urine leakage related to coughing, sneezing, or laughing?	0		1	2	3	4
4. Usually experience small amounts of urine leakage (drops)?	0		1	2	3	4
5. Usually experience difficulty emptying your bladder?	0		1	2	3	4
6. Usually experience pain or discomfort in the lower abdomen or genital region?	0		1	2	3	4
Subtotal for UDI 6= Sum or scores /# answered = ____ x 25 = ____			TOTAL of 3 scores = _____			

PELVIC FLOOR QUESTIONNAIRE

Name_____**Physician**_____**Date**_____

Please describe your main problem_____

_____

When did it begin?_____ Is it getting: better, worse, or staying the same (circle one)

Please describe activities or things that you cannot do because of your problem.

_____

_____

Please list all pelvic and abdominal surgeries with dates of operation.

_____

_____

Date of last pelvic examination_____Date of last urinalysis_____

Special Tests Performed?_____Type_____Date_____

1. OCCURRENCE OF INCONTINENCE OR LEAKAGE
   - Never
   - Less than 1/month
   - More than 1/month
   - Less than 1/week
   - More than 1/week
   - Almost every day
   - #___ leaks per day

2. PROTECTION USED
   - No Protection
   - Pantishields
   - Mini Pad
   - Maxi Pad
   - Bladder control pad type_____
   - Diaper

3. SEVERITY
   - No leakage
   - Few drops
   - Wet underwear
   - Wet outerwear

4. POSITION OR ACTIVITY WITH LEAKAGE
   - Lying down
   - Sitting
   - Standing
   - Changing positions (sit to stand)
   - Sexual activity
   - Strong Urge

5. HOW LONG CAN YOU DELAY THE NEED TO URINATE?
   - Indefinitely
   - 1+ hours
   - ½ hour
   - 15 minutes
   - Less than 10 minutes
   - 1-2 minutes
   - Not at all

6. ACTIVITY THAT CAUSES URINE LOSS
   - Vigorous activity
   - Moderate activity
   - Light activity
   - No activity
   - Type_____

7. PROLAPSE (Falling Out Feeling)
   - Never
   - Occasionally/with menses
   - Pressure at the end of the day
   - Pressure with straining
   - Pressure with standing
   - Perineal pressure all day

8. FREQUENCY OF URINATION (DAYTIME)
   - 0 times per day
   - 1-4
   - 5-8
   - 9-12
   - 13+

9. FREQUENCY OF URINATION (NIGHTTIME)
   - 0 times per night
   - 1
   - 2
   - 3
   - 4+

10. FLUID INTAKE
   - Includes water and beverages
   - 9+ 8oz glasses per day
   - 6-8 8oz glasses per day
   - 3-5 8 oz glasses per day
   - 1-2 8 oz glasses per day
   - How many caffeinated glasses? _____

11. FREQUENCY OF BOWEL MOVEMENTS
   - 2 times per day
   - 1 time per day
   - Every other day
   - Once every 4-7 day
   - Weekly

12. AFTER STARTING TO URINATE, CAN YOU COMPLETELY STOP THE URINE FLOW?
   - Can stop completely
   - Can maintain a deflection of the stream
   - Can partially deflect the urine stream
   - Unable to deflect or slow the stream

13. DO YOU HAVE TROUBLE INITIATING A URINE STREAM?
   - Never
   - More than 1/month
   - Less than 1/week
   - Almost every day

14. ATTITUDE TOWARDS PROBLEM
   - No problem
   - Minor inconvenience
   - Slight problem
   - Moderate problem
   - Major problem

15. CONFIDENCE IN CONTROLLING YOUR PROBLEM
   - Complete confidence
   - Moderate confidence
   - Little confidence
   - No confidence

16. Are you sexually active? Yes_____ No_____
   Are you pregnant or attempting pregnancy? Yes_____ No_____
   Number of pregnancies?_____ Complications?_____
   _____

17. History of or present sexually transmitted diseases? Type_____
_____

18. Do you have pain or problems with sexual activity or urination?
Describe_____
_____

19. Have you ever been taught or prescribed to do pelvic floor/Kegel exercises ?
Yes___No____When?_____ By whom?_____

20. How often do you do pelvic floor exercises?_____

Any comments or concerns not asked?

_____

Overactive bladder symptom score (OABSS)

Circle the score that best applies to your urinary symptoms during the past week

Q1. How many times do you typically urinate, from waking in the morning until sleeping at night?

a. *≤7* = 0
b. *8–14* = 1
c. *≥15* = 2

Q2. How many times do you typically wake up to urinate, from sleeping at night until waking in the morning?

a. *None* = 0
b. *1* = 1
c. *2* = 2
d. *≥3* = 3

Q3. How often do you have a sudden desire to urinate, which is difficult to defer?

a. *None* = 0
b. *Less than once a week* = 1
c. *Once a week or more* = 2
d. *About once a day* = 3
e. *2–4 times a day* = 4
f. *≥5 times a day* = 5

Q4. How often do you leak urine because you cannot defer the sudden desire to urinate?

a. *None* = 0
b. *Less than once a week* = 1
c. *Once a week or more* = 2
d. *About once a day* = 3
e. *2–4 times a day* = 4
f. *≥5 times a day* = 5

TOTAL SCORE = _____ SEVERITY SCORE (mild, mod, severe) = _____

Total score is the sum of the four scores. Severity Score: mild = total score of 3–5 points, moderate = 6–11 points, severe =12 or more points.

Initial number

ICIQ-UI Short Form

CONFIDENTIAL

DAY MONTH YEAR

Today's date

Many people leak urine some of the time. We are trying to find out how many people leak urine, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

1 Please write in your date of birth: ☐☐ ☐☐ ☐☐

DAY MONTH YEAR

2 Are you *(tick one)*: Female ☐ Male ☐

3 How often do you leak urine? *(Tick one box)*

never ☐	0
about once a week or less often ☐	1
two or three times a week ☐	2
about once a day ☐	3
several times a day ☐	4
all the time ☐	5

4 We would like to know how much urine <u>you think</u> leaks.
How much urine do you <u>usually</u> leak (whether you wear protection or not)?
(Tick one box)

none ☐	0
a small amount ☐	2
a moderate amount ☐	4
a large amount ☐	6

5 Overall, how much does leaking urine interfere with your everyday life?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**

not at all — a great deal

ICIQ score: sum scores 3+4+5 ☐☐

6 When does urine leak? *(Please tick all that apply to you)*

never – urine does not leak	☐
leaks before you can get to the toilet	☐
leaks when you cough or sneeze	☐
leaks when you are asleep	☐
leaks when you are physically active/exercising	☐
leaks when you have finished urinating and are dressed	☐
leaks for no obvious reason	☐
leaks all the time	☐

Thank you very much for answering these questions.

Bladder Control Assessment

Urinary Symptoms (Sx)	**Initial**	**Follo w Up**	**Follow Up**	***Outcomes Documentation***	**Initial**	**Follow Up**	**Follow Up**
Date:				**Date:**			
UI Sx how long?		-----	------	**ICIQ-UI Short Form: A: How often do you leak urine?:**			
Sx details *(Yes / No)*				Never [0]			
Frequency (>8/day)				About once a week or less[1]			
Urgency: (sudden, intense, abnormal)				Two to three times a week [2]			
Stress leakage (e.g.Cough, lift, squat)				About once a day [3]			
Urge leakage (leak preceded by urge)				Several times a day [4]			
Nocturia (>1x/night)				All the time[5]			
Eneuresis: (leak with out awareness)				**B: How much urine you think leaks? How much urine do you usually leak (whether you wear protection or not)?**			
Dysuria (Pain)				None [0]			
Able to stop flow				small amount [2]			
Daytime Frequency				moderate amount [4]			
Nighttime Freq.				large amount [6]			
Using pads? Yes or No, # per day				**C: Overall, how much does leaking urine interfere with your everyday life?**			
Type of pads				*Not at all 0 1 2 3 4 5 6 7 8 9 10 a great deal*			
Using Timed voiding? *(yes or no)*				**C: [answer here]**			
Timed Voiding Interval (# hours)				**ICIQ score: sum scores A + B + C =**			
Successful? *(= no leakage between intervals) (Yes / No)*				**When does urine leak? [check all that apply]**			
Water intake *(oz)*				Never- urine does not leak			
Other fluid *(oz)*				Leaks before can get to toilet			
Bowel patterns: Daily BM ? Y or N				Leaks when cough or sneeze			
Bowel Movement how often? (#days)				Leaks when you are asleep			
Constipation? Y / N				Leaks when you are physically active/exercising			
Diarrhea ? *(Yes/No)*				Leaks when you have finished urinating and are dressed			
Fecal Incontinence?				Leaks for no obvious reason			
FI How often?				Leaks all the time			
				Sexually active? *(Yes/ No/ N/A)*			
Therapist Signature				*Number of treatments for UI*			
				Therapist Initials			