FYZICAL THERAPY AND BALANCE CENTERS OF SEQUIM

522 N. 5th Ave. Sequim, WA 98382 **Ph: (360) 683-0632 Fax: (360) 681-5483**

INFORMATION ON TREATMENT FOR PELVIC FLOOR DYSFUNCTION
RELATED TO BOWEL AND BLADDER PROBLEMS

Thank you for choosing
FYZICAL THERAPY AND BALANCE CENTER SEQUIM.

To prepare you for your first visit and to make this visit as productive as possible, please complete the handouts we are sending you:

i. History Questionnaire.
ii. Daily Voiding Log with explanations.

All of the attached forms **MUST** be completed PRIOR to your first appointment.
If this too overwhelming, please call us and we will make other arrangements.
Begin the Voiding Log now (if incontinence is your diagnosis).

- Read the directions "Keeping a record of your bladder function" carefully.
- Then keep track of your food and water intake and urination/bowel movements for 2 full days and nights. There are two identical forms provided for this purpose.

Complete the Patient History form next.
When you come in for your visit on _____ at _____.
Please arrive 20 minutes early to complete the regular office paperwork.
Plan on 60 minutes for the first evaluation visit and 45-60 minute visits thereafter.
The Physical Therapy evaluation and first treatment may include:

- Review of your history
- Musculoskeletal and pelvic floor muscle exam.
- Biofeedback measurements to assess baseline strength of your pelvic floor. This machine records your muscle activity to help to treat your pelvic floor muscles.
- Exercise instruction for pelvic floor muscles.
- The plan for further visits.

Return visits will be scheduled at regular intervals to measure your progress and teach you all the components you need to overcome this challenge. These appointments are important to attend in order to progress your treatment program. Please come even if you did not follow your home program perfectly. We understand it takes time to change habits.

Please feel free to invite someone to accompany you to your appointments if you if doing so will make you feel more comfortable.

If you have any questions, please telephone us at (360) 683-0632

We look forward to meeting you!

FYZICAL®
THERAPY AND BALANCE CENTERS
522 N. Fir St. Sequim, WA 98382
Phone: 360-683-0632 Fax: 360-681-5483

Patient Information

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

Email: _____ Sex: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Alternate: _____

Marital Status: __Single __Married __Divorced __Widowed Social Security #: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician/Family Doctor(s): _____ Phone: _____

Are you currently under the care of a Home Health Agency? __No __Yes, Name of Agency: _____

How did you hear about FYZICAL? __Online __Phone Book __Newspaper __Friend __Other:_____

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. **INITIALS: _____**

Consent to Release Medical Information:
I authorize FYZICAL to release any information acquired in connection with my 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.

Assignment of Insurance Benefits and Guarantee of Payment:
I hereby authorize payment to be made directly to FYZICAL. 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. Insurance coverage is between the patient, employer and/or insurance company.
It is the patient's responsibility to determine physical therapy benefits, authorizations, referrals, co-pays, etc.
It is also the patient's responsibility to follow up with the insurance company on all unpaid visits. If a payment plan is necessary, please contact our Billing Specialist at (360) 683-0632 right away. Accounts past 90 days past due may incur interest up to 12% of the unpaid balance. Any balances over 120 days past due without a payment arrangement will be subject to collection proceedings.

No-Show/Cancellations:
Cancellations or changes should be made 24 hours in advance other than emergency situations.
You may be charged a $25.00 No-Show fee if we are not given 24 hrs. notice.

Protecting your Personal Health Information:
FYZICAL Therapy and Balance will only use and disclose information we collect from you as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. Your Personal Health Information will never be otherwise given to anyone without your written consent.

I authorize disclosure of my information: (<u>please initial next to each one you authorize</u>)

____Any member of my immediate family ____Spouse only ____Other_____

____I authorize detailed information to be left on my voice mail or answering machine.

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

Patient/Responsible Party Signature:_____Date:_____

FYZICAL®

Client Health Questionnaire

Name: _____ DOB: _____ Date: _____

Primary Insurance:_____ Policy #_____ Group# _____

Secondary Insurance:_____ Policy #_____ Group# _____

Policy Holder Name:_____ Relationship to patient: _____

Please describe your Current Complaint or Limitation: _____

Please describe how your problem began: _____

List tests or other interventions for this condition that you have had:_____

Please indicate the daily activities that you cannot perform:_____

Please inform us of any environmental or living conditions you may have difficulties with: _____

Have you fallen in the last year? NO ☐ YES ☐ Did you sustain any injuries from a fall in the last year? NO ☐ YES ☐

If yes, what injury?_____

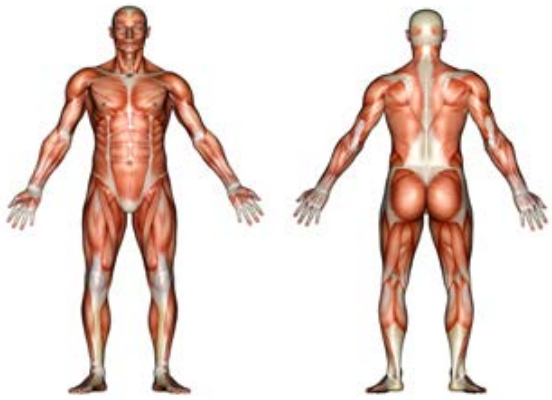
Appointment reminders: ☐ TEXT ☐ CALL

Present: Weight _____ Height _____

Please describe the nature of your symptoms (check all that apply):

- ☐ Fatigue
- ☐ Pregnant
- ☐ Fever/Night Sweats
- ☐ Shortness of breath
- ☐ Ear Pressure/Pain
- ☐ Head Injury/Concussion
- ☐ Persistent pain at night
- ☐ Swelling/Lymphedema
- ☐ Problems with coordination
- ☐ Sudden weakness or fainting
- ☐ Problems with swallowing or speech
- ☐ Unexplained weight loss or loss of appetite
- ☐ Pulsing pain anywhere in your body
- ☐ Constant pain anywhere in your body
- ☐ Swelling or redness in any joints
- ☐ Dizziness/Balance problems/falling

Please mark on the picture locations of pain:



0 1 2 3 4 5 6 7 8 9 10
Pain level at the worst

0 1 2 3 4 5 6 7 8 9 10
Pain level currently

0 1 2 3 4 5 6 7 8 9 10
Pain level at the best

Are you diabetic? NO ☐ YES ☐

Since this condition began, your symptoms have: not changed ☐ increased ☐ decreased ☐

Your symptoms are worse in the: morning ☐ night ☐ afternoon ☐ during the day ☐ same all day ☐

Activities or positions that increase your symptoms: _____

Activities or positions that decrease your symptoms: _____

Occupation: _____ Has your work status changed due to your condition? NO ☐ YES ☐

Employer: _____ Supervisor: _____ Phone: _____

***If you need additional room for medications, please bring a separate document with you to your visit.**

Medication: (Name/Dosage? Frequency/Route Administered: _____

_____

_____

_____

FYZICAL Therapy and Balance
PELVIC FLOOR HEALTH EVALUATION INTAKE FORM

Patient Name:_____ Evaluation Date:_____

Pelvic Health History: Check all that you are experiencing:
___ Urinary Incontinence
___ Anal Incontinence (unintentional loss of stool)
___ Pelvic Prolapse (organ falling out or pressure in perineum)
___ Urgency
___ Too Frequent of Voiding
___ Pelvic Pain
When did your problem(s) first begin? _____
Was your first episode of the problem related to a specific incident? Yes/No _____
On a scale of 0-10, how much does this interfere with your everyday life? (0= not at all to 10=a great deal) _____ /10
How has your lifestyle or quality of life been altered or changed because of this problem?
Household chores (cooking, cleaning, laundry)? __not at all __ slightly __ moderately__ greatly
Physical recreation (walking, swimming, etc.)? __not at all __ slightly __ moderately__ greatly
Entertainment activities (movies, concerts, etc.)? __not at all __ slightly __ moderately__ greatly
Traveling activities for more than 30 minutes (car/bus)? __not at all __ slightly __ moderately__ greatly
Social activities outside home (including work)? __not at all __ slightly __ moderately__ greatly
Emotional health (nervousness, depression, etc.)? __not at all __ slightly __ moderately__ greatly
Other_____

Health History:
General Health: Excellent Good Average Fair Poor Occupation _____
Mental Health: Current level of stress _____High _____Med _____Low Current counseling? Yes/No
Social History: __living alone ___living with spouse ___living with parents
Have you ever had any of the following conditions or diagnoses? Check all that apply
__Latex sensitivity __Childhood bladder problems __Irritable Bowel Syndrome
__Chronic Fatigue Syndrome __Fibromyalgia

Surgical /Procedure History
__bladder surgery __ prostate surgery __reproductive organs
__abdominal organs __bones/joints __back/spine
List:_____

Bladder Habits
Frequency: number of times urinate during day _____ during night _____
Do you have any of the following? (check all that apply)
___Trouble initiating urine stream
___Urinary stream is weak.
___Trouble emptying bladder completely
___Difficulty stopping the urine stream
___Recurrent bladder infections
___Must strain or push to empty bladder.
___Dribbling after urination
___Constant urine leakage
___Blood in urine
___Painful urination
___Trouble feeling bladder urge/fullness

Bowel Habits
Frequency of bowel movements: _____
Do you have any of the following? (check all that apply)
___Pain when passing stool
___Trouble feeling bowel urge/fullness
___Constipation or feeling that must strain to evacuate stool
___Trouble holding back gas or stool
___Strong sense of urgency for bowel movement (BM)
___Feel bowels are not completely empty after bowel movement
___Other: (please specify)_____

FYZICAL Therapy and Balance
PELVIC FLOOR HEALTH EVALUATION INTAKE FORM

Patient Name: _____Evaluation Date: _____

Sexuality:
Are you currently sexually active? Yes/No
Do you have a history of Sexually-transmitted disease? Yes/No
Do you have a history of abuse or rape? Yes/No

Ob/Gyn History (FEMALES) (Check all that apply)
Number of Pregnancies ___ Number of vaginal deliveries ___ Number of Cesarean Section deliveries ___
Complications: __Severe tearing __Forceps __Episiotomy __Vacuum extraction __Baby over 8 lbs,
Menopause? Yes/No Date _____ Pain with vaginal penetration? Yes/No Vaginal dryness? Yes/No

Urogenital History (MALES) (Check all that apply)
__Prostate disorders __Erectile dysfunction __Shy bladder __Pelvic pain __Painful ejaculation
Able to achieve an erection? Yes/No Able to maintain an erection? Yes/No Pain with an erection? Yes/No
Other: describe_____
Please complete the following sections that apply to you:

URINARY URGENCY Section: ____ THIS DOES NOT APPLY
Activities/events that **cause or aggravate** your symptoms (Check all that apply)
___ With triggers (i.e. running water or key in door)
___ With anxiety or stress
___ With night time urination
___ With cold weather
Specify: _____

URINARY INCONTINENCE Section: ____ THIS DOES NOT APPLY
Activities/events that **cause or aggravate** your symptoms. (Check all that apply)
___ Sitting greater than ___minutes
___ Walking greater than ___minutes
___ Standing greater than __ minutes
___ Changing positions (i.e. stand from sitting).
___ Light activity
___ With anxiety or stress
___ Sexual activity/ intercourse.
___ Other, please list_____
___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers (i.e. running water or key in door)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sleeping
What **relieves** your symptoms?_____
How **often** do you leak urine __ never __ about once a week or less __ 2-3 times a week
__ about once per day __ several times per day __ all the time.
On average, how **much** urine do you USUALLY leak (whether you wear protection or not)
__ Just a few drops= small amount
__ Wets underwear= moderate amount
__ Wets outerwear= large amount
__ Wets the floor
What form of **protection** do you wear?
___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
___Other _____
On average, how many pad changes are required in 24 hours? ___# of pads

PELVIC PAIN Section: ____ THIS DOES NOT APPLY
If you are currently experiencing pain, please rate your pain on a 0-10 scale with 10 being the worst.
(circle): 1 2 3 4 5 6 7 8 9 10 **Also complete Client Health Questionnaire**
Where is your pain? Mark on picture or describe:_____
Describe the nature of the pain (burning, ache):_____
Frequency of pain (constant, intermittent):_____
When do you experience pain or when do you notice a worsening of your pain?_____
_____
Do you have tingling or numbness? Yes/No _____

FYZICAL Therapy and Balance
PELVIC FLOOR HEALTH EVALUATION INTAKE FORM

Patient Name: _____Evaluation Date: _____

Sexuality:

PROLAPSE Section: (also known as rectocele or cystocele) ____ THIS DOES NOT APPLY

Rate a feeling of **organ "falling out"** or heaviness/pressure in perineum

___None present but doctor said it is an issue.
___Times per month (specify if related to activity or your period)
___With standing for _____ minutes or _____hours.
___With exertion or straining
___Other

ANAL INCONTINENCE Section: ____ THIS DOES NOT APPLY

Activities/events that **cause or aggravate** your symptoms_____
What **relieves** your symptoms?_____
How **often** do you leak stool __ about once a week or less __ 2-3 times a week __ about once per day
__ several times per day __ all the time.
On average, how **much** stool do you usually leak (whether you wear protection or not)? _____
What form of **protection** do you wear? _____

KEEPING A RECORD OF BLADDER FUNCTION

The main purpose of a bladder log is to document how well your bladder and bowel functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns.
At first, the log is used as an evaluation tool. Later, it will be used to measure your progress.
Please complete a bladder log **every day** for **2 days** and bring it with you to your appointment.
Your log will be more accurate if you fill it out as you go through the day.
It can be very difficult to remember at the end of the day exactly what happened in the morning.
INSTRUCTIONS -- see sample page for examples,

Column 1 - Time of Day

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold.
Select the hour block that corresponds with the time of day you are recording information.

Column 2 - Type & Amount of Fluid & Food Intake

- Record the type and amount of fluid you drank
- Record the type and amount of food you ate
- Circle the time when you woke up for the day and the hour you went to sleep

Column 3 - Amount Voided (Urinated); Three methods for amount

Record the time of day and amount voided. Use the first method (unless you prefer others).

1. Place an S, M, L, in the box at the corresponding time each time you urinate.
   S - SMALL= seemed like a small amount, or urinated "just in case".
   M - MEDIUM = seemed like an 8 ounce measuring cup would run over.
   L - LARGE = seemed like the amount you urinate when you first wake up in the morning.
2. If you have difficulty gauging the amount of urine, you may record seconds by counting. "one - one thousand" (this equals one second) while emptying your bladder. Record the total number of seconds it took you to void.
3. Measure urine amounts with a collection device. The best method is a collection "hat". The "hat" can be placed directly over the toilet. Ask your provider where to get one. Some people use 2-4 cup measuring containers, but it is sometimes difficult to catch the urine with these. Record the measured ounces of urine in the box at the corresponding time interval each time you urinate.

Column 3 - Occurrence of Bowel Movement:

Record a bowel movement by writing "BM" at the appropriate time.

Column 4 - Amount of leakage Record the amount of urine loss at the time it occurred.

S - SMALL = drop or two of urine
M - MEDIUM = wet underwear
L - LARGE = wet outerwear or floor

Column 5 - Was Urge Present - Describe the urge sensation you had as:

1- MILD = first sensation of need to go
2- MODERATE = stronger sensation or need
3- STRONG = need to get to toilet, move aside

Column 6 - Activity with leakage

Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, bent over, lifted something or had a strong urge, in the comments section (at the bottom of the log table).
Record any special problems and medication changes/issues.
If a pad change was needed, record the number used during the day at the bottom of the page.

Daily Voiding Log - Completed Example

Time of Day	Type of food, Amount of Food & Fluid Intake	Amount Voided in Ounces S/M/L or #Seconds	Amount of Leakage S/M/L	Was Urge Present 1=Mild, 3=Severe 1/2/3	Activity with Leakage
Midnight					
1:00am		S			
2:00am					
3:00am					
4:00am					
5:00am					
6:00am	Woke up at 6:45am	L BM		3	
7:00am	Coffee 2 cups, bagel				
8:00am			M		Fast Walking
9:00am	Apple	M		2	
10:00am					
11:00am		S		1	Key in the door
NOON (12pm)	Tuna sandwich, milk 8oz, pear				
1:00pm					
2:00pm		M		2	
3:00pm	Tea 1 cup, cookies		S		Running Water
4:00pm	Water 1 cup				
5:00pm					
6:00pm	Chicken, corn pudding, salad, apple juice 12 ounces	M		3	
7:00pm					
8:00pm	Chocolate		S	3	
9:00pm					
10:00pm	To bed at 10:30pm	M		3	
11:00pm					
					Number of Pads: 2
Comments:					

Daily Voiding Log DAY 1 - _____

Time of Day	Type of food, Amount of Food & Fluid Intake	Amount Voided in Ounces S/M/L or #Seconds	Amount of Leakage S/M/L	Was Urge Present 1=Mild, 3=Severe 1/2/3	Activity with Leakage
Midnight					
1:00am					
2:00am					
3:00am					
4:00am					
5:00am					
6:00am					
7:00am					
8:00am					
9:00am					
10:00am					
11:00am					
NOON (12pm)					
1:00pm					
2:00pm					
3:00pm					
4:00pm					
5:00pm					
6:00pm					
7:00pm					
8:00pm					
9:00pm					
10:00pm					
11:00pm					
					Number of Pads:
Comments:					

Daily Voiding Log DAY 2 - _____

Time of Day	Type of food, Amount of Food & Fluid Intake	Amount Voided in Ounces S/M/L or #Seconds	Amount of Leakage S/M/L	Was Urge Present 1=Mild, 3=Severe 1/2/3	Activity with Leakage
Midnight					
1:00am					
2:00am					
3:00am					
4:00am					
5:00am					
6:00am					
7:00am					
8:00am					
9:00am					
10:00am					
11:00am					
NOON (12pm)					
1:00pm					
2:00pm					
3:00pm					
4:00pm					
5:00pm					
6:00pm					
7:00pm					
8:00pm					
9:00pm					
10:00pm					
11:00pm					
					Number of Pads:
Comments:					