

*Doctors & Therapist from Multiple Specialties Working Together for Every Patient.***PATIENT INFORMATION FORM**

Date: \_\_\_\_\_ Patient # \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber's Social Security Number: \_\_\_\_\_

Relationship to Patient: ☐ Self ☐ Spouse ☐ ParentAre any of these problems related to: ☐ Work Injury ☐ Auto Accident ☐ Other: \_\_\_\_\_

Who is your Primary Care Provider?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact and Phone Number: \_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouses Name: \_\_\_\_\_

Child's Name and Age: \_\_\_\_\_

Child's Name and Age: \_\_\_\_\_

Child's Name and Age: \_\_\_\_\_

Child's Name and Age: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

(Please be specific so we can thank them)

Have you consulted a chiropractor before? ☐ Yes ☐ No When? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## PELVIC FLOOR PHYSICAL THERAPY QUESTIONNAIRE

Please answer the following questionnaire to the best of your ability. The therapist will review these answers with you during your appointment.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### HISTORY

1. Number of total pregnancies: \_\_\_\_\_
  - a. Of these pregnancies, how many were vaginal deliveries: \_\_\_\_\_
  - b. Of these pregnancies, how many were Cesarean deliveries: \_\_\_\_\_
2. Number of episiotomies or tears: \_\_\_\_\_
  - a. If a tear, please specify what grade: \_\_\_\_\_
3. Date of last pap smear: \_\_\_\_\_
4. Please list any applicable past surgeries (i.e. hysterectomy, laparoscopy, vaginal reconstruction)

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### PAIN

5. Do you have pain with any of the following: (please circle YES or NO)
- |                                  |     |    |
|----------------------------------|-----|----|
| a. Sexual intercourse            | YES | NO |
| b. Pelvic Exams                  | YES | NO |
| c. Tampon use                    | YES | NO |
| d. Menstrual Cup use             | YES | NO |
| e. Pain in back, abdomen or legs | YES | NO |

### BLADDER SYMPTOMS (If any applies to you, please circle YES or NO)

6. Do you leak urine YES NO
- a. Please describe during what activities you leak urine

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- b. Please describe the amount of leakage

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- |   |     |    |
|---|-----|----|
| 7. Have a strong urge to urinate                    | YES | NO |
| 8. Wet the bed                                      | YES | NO |
| 9. Experience burning pain when you urinate         | YES | NO |
| 10. Experience incomplete bladder emptying          | YES | NO |
| 11. Have feeling of heaviness in perineum           | YES | NO |
| 12. Pelvic tissue protruding out of vaginal opening | YES | NO |
| 13. Urinate more than 7 times a day                 | YES | NO |

### BOWEL SYMPTOMS (If any applies to you, please circle YES or NO)

- |  |                     |    |
|--|---------------------|----|
| 14. Strain to have a bowel movement              | YES                 | NO |
| 15. Include fiber in your diet                   | YES                 | NO |
| 16. Take laxatives /get enemas regularly         | YES                 | NO |
| 17. Leak or stain feces by accident              | YES                 | NO |
| 18. Leak gas by accident                         | YES                 | NO |
| 19. Heavy a very strong urge to move your bowels | YES                 | NO |
| 20. Heavy diarrhea often                         | YES                 | NO |
| 21. How often do you move your bowels: _____     | per day or per week |    |

### INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION

During the physical therapy evaluation, an assessment of your low back, hips, and pelvic girdle will be performed by a physical therapist in order to identify any musculoskeletal problems for the problems you have reported. This may include an evaluation of your pelvic floor muscles for strength, resting tone (tightness), and coordination (contract/relax). These findings will be discussed with you, and you will then work with your physical therapist to develop a treatment plan that is appropriate for YOU. **Your evaluation MAY include an internal assessment of the pelvic floor muscles, which could be completed vaginally (females) or rectally (males & females).** A biofeedback assessment of your pelvic floor muscles may also be performed and may include internal or external sensors. Your physical therapist will discuss this option if necessary for your evaluation, and will ask for your verbal consent BEFORE initiating this exam. **You can decline this part of this examination and say NO.** Your physical therapist can assess and treat the pelvic floor muscles externally (from the outside) if needed. The assessment of the pelvic floor muscles may result in temporary soreness or discomfort. Please discuss your symptoms with your physical therapist if this occurs. \_\_\_\_ (initial here)

We realize that many patients may be apprehensive because of the private nature of the condition and the examination. Please ask as many questions as you need to increase your comfort and understanding of your evaluation, its findings, and treatment. Please discuss any concerns or hesitation that you may have with your physical therapist. \_\_\_\_ (initial here)

**By signing this form, you agree and understand that treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat as discussed.** You are always free to change your mind at any time during your course of treatment, and you are encouraged to notify your physical therapist of any changes of your preferences. \_\_\_\_ (initial here)

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.

**CONSENT:** I have read and understand the Informed Consent for Pelvic Floor Muscle Evaluation, and I consent to the evaluation and treatment, unless otherwise noted below. Please list below any exception to consent. If none, please write "none": \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**For Office Use Only:**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Provider Initial: \_\_\_\_\_

**Acknowledgements**

*To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.*

*Initials*

\_\_\_\_\_ I instruct the provider to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health.

\_\_\_\_\_ I acknowledge and may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

\_\_\_\_\_ I realized that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): \_\_\_\_\_

\_\_\_\_\_ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

\_\_\_\_\_ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I received.

\_\_\_\_\_ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

\_\_\_\_\_ I acknowledge that a 24-hour cancellation notice is required. Without proper notification a missed appointment may result in a \$50 cancellation fee.

Signature: \_\_\_\_\_

Date (MM/DD/YYYY): \_\_\_\_\_

# Pelvic Floor Disability Index (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.

**Symptom scale:**

- 0 = not present**
- 1 = not at all**
- 2 = somewhat**
- 3 = moderately**
- 4 = quite a bit**

## 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.

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