

## Welcome to Pelvic Therapy Specialists, PC

So that your first visit and evaluation may be as efficient and productive as possible, following are some forms that we ask you to fill out before your appointment.

Doing so before your appointment will minimize time spent filling out forms and allow more time to answer your questions and start treatment. Additionally, patients typically remember more pertinent facts concerning their medical history when pre-evaluation forms are completed in the comfort of their homes.

Following you will find:

Pre-Evaluation Questionnaire  
Insurance Waiver Form for Cash Pay Patients  
Informed Consent for Treatment of Pelvic Floor  
Cancellation and No Show Policy  
HIPPA Privacy Notice

Thank you for choosing Pelvic Therapy Specialists for your physical therapy care.

We look forward to working with you.

Sincerely,



Sandra Shevlin, DPT





## **PRE-EVALUATION QUESTIONNAIRE**

Please remember to bring in completed forms to your first appointment.

Name \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer Name \_\_\_\_\_

Referring Physician Name \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Work Ph \_\_\_\_\_ Fax \_\_\_\_\_

Primary Care Physician Name \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Work Ph \_\_\_\_\_ Fax \_\_\_\_\_

**Reason for your visit:** \_\_\_\_\_

\_\_\_\_\_

List **medications, nutritional supplements, and over the counter drugs** you are currently on:

\_\_\_\_\_

List any medication allergies: \_\_\_\_\_

Are you experiencing any weakness? Yes / No Where? \_\_\_\_\_

Are you experiencing any numbness? Yes / No Where? \_\_\_\_\_

Are you experiencing any tingling or pins / needles sensation? Yes / No Where? \_\_\_\_\_

Have you had any **sudden** weight loss or sudden weight gain? Yes / No Explain \_\_\_\_\_

\_\_\_\_\_



**Job and Daily Lifestyle Activities** (circle your usual daily activities, if applicable)

**Standing:** 2 hrs 4 hrs 6 hrs 8 hrs

**Walking:** less than 100 feet 500 feet ¼+ mile

**Bending:** none / occasional / frequent

**Climbing:** none / occasional / frequent

**Reaching:** none / occasional / frequent

**Type of reaching:** floor to waist waist to shoulder overhead

**Lifting:** light / moderate / heavy

5 lbs frequently / occasionally 10s frequently / occasionally

25bs frequently / occasionally 50bs frequently / occasionally

Please describe your usual **mode, duration, and frequency of exercise:**

Do you drink alcohol? Y / N How many drinks do you have a day / week? \_\_\_\_\_

Do you smoke cigarettes? Y / N How many cigarettes / packs do you smoke daily? \_\_\_\_\_

Are you able to work? Yes / No / Part-time

**Medical History** (please circle letters for: Never, Once, Sometimes, Frequent, Currently)

Bladder infection N - O - S - F - C	Menopause Yes / No	Arthritis N - O - S - F - C
Vaginal infection N - O - S - F - C	Constipation N - O - S - F - C	Neurological disorder N - O - S - F - C
Kidney infection N - O - S - F - C	Difficulty sitting N - O - S - F - C	COPD N - O - S - F - C
Urinary incontinence N - O - S - F - C	High blood pressure N - O - S - F - C	Fibromyalgia N - O - S - F - C
Fecal incontinence N - O - S - F - C	Hemorrhoids N - O - S - F - C	Chronic fatigue N - O - S - F - C
Pelvic/abdominal adhesions N - O - S - F - C	Diabetes N - O - S - F - C	Allergies/sinusitis N - O - S - F - C
Pelvic pain N - O - S - F - C	Cancer N - O - S - F - C	Emphysema/bronchitis N - O - S - F - C



**Medical History - continued** (circle letters for: Never, Once, Sometimes, Frequent, Currently)

Abdominal pain N - O - S - F - C	Cardiovascular disease N - O - S - F - C	Depression N - O - S - F - C
Hormonal problems N - O - S - F - C	Thyroid problems N - O - S - F - C	Headaches N - O - S - F - C
Endometriosis Yes / No	Liver disorder N - O - S - F - C	Anxiety N - O - S - F - C
Pelvic inflam. Disease N - O - S - F - C	Interstitial cystitis N - O - S - F - C	Digestive problems N - O - S - F - C
Prolapse (if known) N - O - S - F - C	Cysts N - O - S - F - C	Multiple sclerosis N - O - S - F - C
Painful intercourse N - O - S - F - C	Fibroids N - O - S - F - C	Sexually transmitted disease N - O - S - F - C
Other:		

**History of surgeries and traumas, *with approximate dates:***

Appendectomy	Hysterectomy (total/partial)	Pacemaker
Laparoscopy	C-section	Radiation therapy
Gall bladder removal	Episiotomy	Falls on tailbone, back, hip
Surgery/biopsy to cervix	Abortion	Hit on head/back
Bladder repair	D & C	Physical or sexual abuse
Abdominal surgery	Low back/hip injury	Pelvic surgery
Pins/plates/screws inserted	Other:	



**Discomfort Feedback**

If you have pain or discomfort anywhere in the body, even if you don't think it is related, please complete the questions below:

Rate your pain area on a scale of 0 -10 when the pain is at it's Min #\_\_\_/10 and at it's Max \_\_\_/10. (0 = no pain : 10 worst pain).

**Worst pain area:** \_\_\_\_\_ Min\_\_\_/10 Max\_\_\_/10

**Pains is:** dull / sharp shooting / burning / cramping / pressure and is it constant / intermittent

**Next worst pain area:** \_\_\_\_\_ Min\_\_\_/10 Max\_\_\_/10

**Pains is:** dull / sharp shooting / burning / cramping / pressure and is it constant / intermittent

**Please list any additional areas of pain:** \_\_\_\_\_

**Pain began:** gradually / suddenly on / around (date): \_\_\_\_\_ due to (if known) \_\_\_\_\_

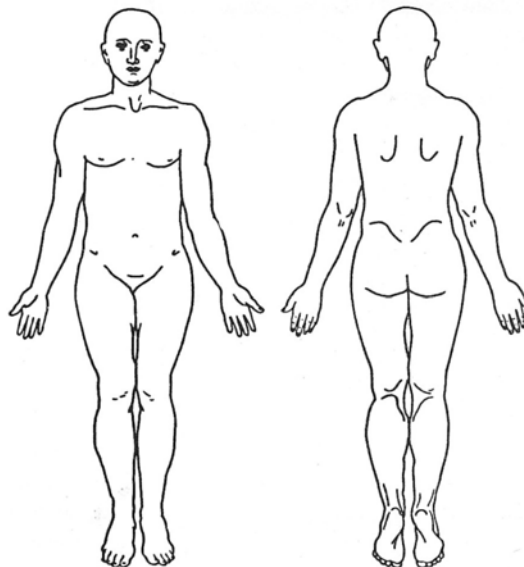
**Pain began:** in the \_\_\_\_\_ and spread to \_\_\_\_\_

**Since onset pain has:** increased / decreased / stayed the same in severity / frequency / duration

**Pain increases with:** lifting / sitting / standing / walking / bending / climbing / driving / sexual intercourse / reaching / housekeeping / social activities / work activities / weather changes / sneezing / deep breathing / coughing / Other: \_\_\_\_\_

**Pain decreases with:** rest / ice / heat / postural or positional changes / other \_\_\_\_\_

**Please mark diagram below to show the therapist where you experience your symptoms**





**If you have bladder problems and/or urine leakage please answer questions below:**

1. Do you leak urine when you cough, sneeze, or laugh? \_\_\_\_\_
2. Do you ever have such an uncomfortably strong need to urinate that if you don't reach the toilet you will leak? \_\_\_\_\_
3. If "yes" to question No. 2, do you ever leak before you reach the toilet? \_\_\_\_\_
4. How many times during the day do you urinate? \_\_\_\_\_
5. How many times do you void (urinate) during the night, after going to bed?
6. Have you wet the bed in the past year? \_\_\_\_\_
7. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry? \_\_\_\_\_
8. Do you ever leak urine during or after sexual intercourse? \_\_\_\_\_
9. Do you find it necessary to wear a pad because of your leaking? \_\_\_\_\_
10. How often do you leak urine? \_\_\_\_\_
11. Have you had bladder, urine, or kidney infections?
12. Are you troubled by pain or discomfort when you urinate? \_\_\_\_\_
13. Have you had blood in your urine? \_\_\_\_\_
14. Do you find it hard to begin urinating? \_\_\_\_\_
15. Do you have a slow urine stream? \_\_\_\_\_
16. Do you have to strain to pass your urine? \_\_\_\_\_
17. After you urinate, do you have dribbling, or a feeling that your bladder is still full?  
\_\_\_\_\_
18. Do you/have you ever experienced a dragging or "falling out" sensation of the perineal or pelvic floor area? \_\_\_\_\_
19. Do you empty your bladder frequently, before you experience the desire to pass urine just so you can stay dry? \_\_\_\_\_
20. Circle type of protection worn:  

No protection	Pantishields	Mini Pad
Maxi Pad	Diaper / Serenity	



**If you have bladder problems and/or urine leakage please answer questions below  
(continued)**

21. Position or activity with leakage:

Lying Down	Sitting	Standing
Sexual Activity	Changing Positions (sit to stand, etc)	

22. How long can you delay the need to urinate?

1+ hours	½ hour	15 minutes
< 10 minutes	1-2 minutes	Not at all

23. Activity that causes urine loss:

Vigorous activity	Moderate activity	Light Activity	No activity
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24. Date of last internal exam/check up: \_\_\_\_\_

**Pregnancy/Birth History (if applicable)**

- Are you pregnant now? Yes / No / Maybe If yes, how far along are you? \_\_\_\_\_
- Have you ever had or are you currently experiencing pregnancy related complications?  
\_\_\_\_\_
- Number of pregnancies \_\_\_\_\_ Number of deliveries \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Child Weight \_\_\_\_\_ Complications \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Child Weight \_\_\_\_\_ Complications \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Child Weight \_\_\_\_\_ Complications \_\_\_\_\_

**Menstruation History** (if applicable)

- Frequency of your periods (in days) \_\_\_\_\_
- How long does your period last (in days) \_\_\_\_\_
- Do you ever experience pain with your periods? Yes / No
- If yes, do you need medication? Yes / No



**Pelvic Therapy  
Specialists, PC**

## **INSURANCE WAIVER FORM FOR CASH PAY PATIENTS**

I have opted to not to use my out of network health insurance benefits (if available) to obtain a discounted cash pay rate.

I waive the ability to submit claims and bills retroactively to my health insurance company for physical therapy services rendered by Pelvic Therapy Specialists, PC.

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Patient Name

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Patient or Guardian Signature

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Date



## **INFORMED CONSENT FOR ASSESSMENT OF THE PELVIC FLOOR AND GENERALIZED EVALUATION AND TREATMENT**

I understand that with referral to physical therapy for a pelvic floor dysfunction and/or biofeedback, it may be beneficial for my therapist to perform a *muscle assessment of the pelvic floor*. Palpation of these muscles is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain, urinary incontinence, dyspareunia (pain with intercourse), pain from episiotomy or scarring, vulvodynia, vestibulitis or other similar diagnoses.

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

Treatment procedures for pelvic floor can include biofeedback, electrical stimulation, and use of vaginal weights and/or manual techniques such as massage or soft tissue work.

The therapist will explain all procedures to be used in my treatment, and I may choose not to participate with all or part of the treatment plan.

Based on the information I have received from the therapist, I voluntarily agree to the standard assessment and treatment plans for my condition.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

***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 KY jelly, vaginal creams or latex, please inform the therapist prior to the pelvic floor assessment.***



## **CANCELLATION AND NO-SHOW POLICY**

We are committed to exceptional patient service and clinical care to expedite the healing and recovery process. To accomplish this, it is extremely important that you attend each of your scheduled appointments.

- **Scheduling** is based on a first come, first served basis. It is advisable for you to schedule your appointments in four to six week intervals (if needed) to ensure treatment continuity, as schedules are **commonly booked** for the immediate two weeks.
- In the event that you need to cancel an appointment, **we request at least 48 business hours notice**. Cancellation less than 48 hours can mean that we may not be able to schedule another patient who may be in need of our services.
- In the event of a late cancellation or "no-show," **your account will be assessed a \$35 cancellation fee**. This charge will **not be covered by insurance** but will have to be paid by you personally. By signing below you **authorize permission for Pelvic Therapy Specialists to run your credit card** at the time. In the event that we do not have proper credit card information, you will be billed for your cancellation fee.
- We understand that emergencies do occur – late cancellation due to severe weather, illness and family emergency is excluded from this policy. For women, internal treatment while having a period is common. Additionally, we may be able to work on secondary areas that may be a part of your pain and/or symptoms.
- **Arriving on time for your appointment is critical** to the optimal delivery of care. Chronic late arrivals are disruptive to the successful implementation of your patient care plan. Appointment times will still end at the scheduled time regardless of what time you arrive.

I understand the terms of this form. I agree to be financially responsible to pay for charges incurred from cancellations made less than 48 hours or no shows. I authorize Pelvic Therapy Specialists, PC to charge my credit card in the event of a cancellation or no show.

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Patient or Guardian Signature

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Date



**Pelvic Therapy  
Specialists, PC**

## **HIPPA PRIVACY NOTICE**

If you have questions and/or would like additional information regarding the uses and disclosures of your health information, you may contact our Privacy Officer at:

Pelvic Therapy Specialists, PC  
c/o Sandra Shevlin, DPT  
5377 Manhattan Circle, Suite #104  
Boulder, CO 80303  
Ph 303-601-7495

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201. Complaints filed directly with the secretary must be made in writing, name us, describe the acts or omissions in violation of the privacy rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted to us must be in writing and to the attention of our Privacy Officer. There will not be retaliation for filing a complaint.

By signing below, I hereby acknowledge receipt of this privacy notice.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Patient or Patient's Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative's Relationship to Patient (if applicable)

*To be completed by Pelvic Therapy Specialists, PC:*

*After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s) \_\_\_\_\_*

\_\_\_\_\_

\_\_\_\_\_  
*Pelvic Therapy Specialists Representative Signature*

\_\_\_\_\_  
*Date*