

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
Confidentiality and Financial Policy
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) _____

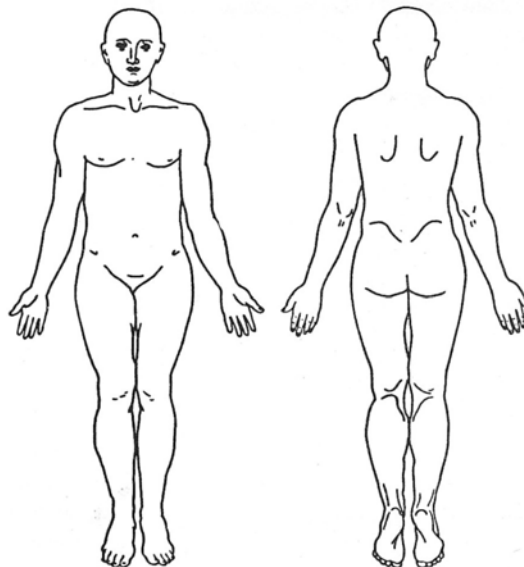
Pain began: in the _____ and spread to _____

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



CONFIDENTIALITY AND FINANCIAL POLICY

I hereby authorize Pelvic Therapy Specialists, PC to furnish information to insurance carriers concerning my diagnosis and treatment and I hereby assign to the physical therapist all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance. All professional services rendered are charged to the patient. Payments may be arranged. Failure to make payment when requested is basis for legal action and the undersigned agrees to pay all costs of collection including a reasonable fee and hereby waive their right of exemption under the law of the State of Colorado and any other state. I have received a copy of the Pelvic Therapy Specialists, PC confidentiality financial policy and understand its content.

Patient or Guardian Signature _____ Date _____

Responsibility for Non-Covered Services

Pelvic Therapy Specialists, PC and /or referring physicians may determine that there are certain routine services that are necessary for the maintenance of good health and standard medical care that are not covered by my Medicare contract or other insurance contracts. I hereby acknowledge, understand and agree to be fully responsible for any and all amounts charged by Pelvic Therapy Specialists, PC for such non-covered services. Pelvic Therapy Specialists, PC will order only supplies that are deemed medically necessary for the patient's treatment and care. Any questions regarding whether a certain service is covered by Medicare or other insurance contracts should be discussed with your insurance carrier or Medicare. I hereby acknowledge, understand and agree that I have read the non-covered routine services policy of Pelvic Therapy Specialists, PC and agree to pay for any and all services not covered by my Medicare or other insurance contract. This may include, but not be limited, to the following services: Biofeedback / e-stim units, orthopedic supplies and swiss balls.

Patient or Guardian Signature _____ 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.

Patient or Guardian Signature

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