Greenwood Physical Therapy
268 Greenwood Ave., Suite 202
Bethel, CT 06801
Tel: 203-917-4792 Fax: 203-917-4798

PELVIC FLOOR INTAKE FORM

Name: _____ **Date of Birth:** ____/____/_____

Referring Physician:_____ **Family Physician same** ☐_____

SOCIAL HISTORY

With whom do you live?

Alone ___ Spouse/significant other ___ Spouse/significant other and children ___ Children only ___
Parents ___ Other relatives ___ Group setting ___ Personal care attendant ___
Other _____

Employment

Working full time ____
Working part time ____
Currently not working due to condition ____
Homemaker ___ Student ___ Retired ___ Unemployed ___
Occupation: _____
Right handed ___ Left handed ___

LIVING ENVIRONMENT

Does your home have?

___ Stairs, no railing
___ Stairs, railing
___ Ramps
___ Elevator
___ Uneven terrain

Do you use?

___ Cane
___ Walker
___ Manual wheelchair
___ Motorized wheelchair
___ Glasses ___ hearing aides
Other:_____

Where do you live?

Private home ___ Condo ___ Apartment ___ Trailer ___ Other: _____

GENERAL HEALTH STATUS

Please rate your health:
Excellent ___ Good ___ Fair ___ Poor ___

MEDICAL HISTORY (Have you had or do you currently have any of the following?)

___ Asthma, Bronchitis, Emphysema
___ Shortness of Breath/Chest Pain
___ Coronary Artery Disease
___ Do you have a pacemaker
___ High Blood Pressure
___ Heart Attack/Heart Surgery
___ Blood Clot
___ Stroke/TIA
___ Allergies
___ Pins or Metal Implants
___ Sever or Frequent Headaches
___ Vision or Hearing Difficulty
___ Numbness or Tingling
___ Dizziness or fainting
___ Weakness
___ Weight Loss/Energy Loss
___ Hernia
___ Epilepsy/Seizures
___ Thyroid Issues ___ hypo ___ hyper
___ Incontinence

___ Joint Replacements
___ Diabetes
___ Infectious Disease
___ Cancer
___ Elbow/Hand Injury/Pain
___ Radiation
___ Arthritis
___ Osteoporosis
___ Sleeping Difficulties
___ Latex Allergies
___ Bladder Infections
___ Difficult Childbirth

___ Pelvic Pain
___ Neck Injury/Pain
___ Shoulder Injury/Pain
___ Lymph nodes removed
___ Chemo
___ Back Injury/Pain
___ Knee Injury/Pain
___ Leg/Ankle/Foot Injury/Pain
___ Multiple Sclerosis
___Parkinson's
___ Vaginal Dryness
___ Menopause (onset date ___)

Other _____

Have you ever had surgery? Yes ___ No ___ If yes, please describe, and include dates: _____

_____

_____

CURRENT CONDITION(S) / CHIEF COMPLAINT(S)
Describe the problem(s) for which you seek physical therapy: _____

_____

What do you hope to gain from physical therapy? _____

Current Pain: 0 1 2 3 4 5 6 7 8 9 10
Pain at Best: 0 1 2 3 4 5 6 7 8 9 10
Pain at Worst: 0 1 2 3 4 5 6 7 8 9 10

Please describe your pain: constant ___ intermittent ___ sharp ___ dull ___ aching ___ stabbing ___ pins/needles ___ numbness ___

Does your pain awaken you at night? Yes ___ No ___
How long do you sleep before waking with pain? _____
Where is your pain located? _____
Do you have days or periods of time when you are completely pain free? Yes ____ No ____

When did these problem(s) begin? _____
Was the onset gradual? Yes ___ No ___
If there was an injury, describe the injury:

_____

How is your current condition progressing overall? Improving ___ Staying the same ___
Getting worse ___
What makes the problem(s) better? Heat ___ Ice ___ Rest ___ Medication ___ Other _____

What makes the problem(s) worse? Sitting ___ walking ___ standing ___ stairs ___ bending ___ squatting ___ push/pull ___ kneeling ___ reaching ___ lifting ___ rising from a chair ___ intercourse, pelvic exam, tampon use ___ Other _____

Are you able to continue your usual recreational activities? Yes ___ No Limited ___ - Explain: _____

_____

MEDICATIONS

Do you take any Physician prescribed medications? (check all that apply)

___ Aspirin
___ Muscle Relaxers
___ Prescribed pain relievers
___ Anti-inflammatories
___ Water pills (diuretics)
___ Stomach/ulcer pills
___ Antibiotics
___ Asthma medication
___ Antidepressant medication
___ Blood Thinners
___ Hormone replacement therapy
___ Birth control pills
___ High blood pressure medications
___ Cholesterol medication
___ Heart medications (other than for high blood pressure)
___ Thyroid medication
___ Insulin
___ Seizure medication

Other: _____

Do you take any nonprescription medications (including vitamins, supplements)?

_____

Are you allergic to any medications that you know of? _____

Symptom Questionnaire

Bladder leakage frequency:

___ Never ___ Only with strong cough/sneeze ___ only premenstrual
___ Constant ___ # per month/week/day (circle appropriate response)

Severity of leakage:

___ No leakage ___ Few drops ___Wets underwear ___Wets outerwear

Protection worn:

___None ___Pantishields ___Minipads ___Maxipad ___Poise pad ___other: _____

Leakage caused or increased by:

___ Vigorous activity or exercise ___ Light activity ___ changing positions (sit to stand)
___ Walking to the toilet ___ Strong Urge to go ___ Intercourse or sexual activity
___ Other _____

Position or activity with leakage:

___ Lying down ___ Sitting ___ Standing

How long can you delay the need to urinate:

___ Not at all ___ 1-2 min ___ 3-10 min ___ 11-30 min ___ 31-60 min ___ Hours

Rate a feeling of "falling out" or pelvic heaviness/pressure:

___ None ___Only with menstruation ___ With standing ___ With exertion
___ At the end of the day ___ Constant ___Other _____

Fluid Intake (one glass = 8 oz)

___ glasses per day ___ # of caffeinated per day ___ # of alcoholic per day

Rate your feelings as to the severity of this problem from 0-10 with 10 being the worst

0 _____ 10

Rate the following statement as it applies to you today

My bladder is controlling my life.

0 _____ 10

Bladder Habits

How often do you urinate during the day? _____ # of times

How often do you urinate after going to bed? _____ # of times

Do you take your time to go to the toilet and empty your bladder? Y/N

Number of bladder infections in the last year? _____

Can you stop the flow of urine when on the toilet? Y/N

Is the volume of urine passed usually; Large/Average/Small/Very Small

Do you have the sensation that you need to go to the toilet? Y/N

Do you strain to pass urine? Y/N

Do you empty your bladder frequently, before you experience the urge to pass urine? Y/N

Do you have the feeling your bladder is still full after urinating? Y/N

Do you have a slow or hesitant urinary stream? Y/N

Do you have difficulty initiating the urine stream? Y/N

Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, etc.)
Y/N, please list _____

Bowel Habits

Frequency of bowel movements _____ per day _____ per week

Consistency of stool ___ loose ___ Normal ___ Hard

Do you have a history of constipation? Y/N

Do you currently strain to go? Y/N

Do you ever ignore the urge to defecate? Y/N

Do you have trouble making it to the toilet on time when you have the urge to go? Y/N

By signing below you are acknowledging all information above is accurate and complete to the best of your knowledge.

Patient Signature: _____ Date: _____

General Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred to Greenwood Physical Therapy for evaluation and treatment of Pelvic Floor Dysfunction. I understand that to evaluate my condition it may be necessary, initially and periodically, to have my physical therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length. Such evaluation and treatment may include, but not limited to, the following: observation, palpation, use of vaginal cones, vaginal or rectal sensors for biofeedback and/or electrical stimulation, exercise, internal soft tissue mobilization, education, instruction and neuromuscular techniques of the perineal area. Treatment may also include joint mobilization, modalities such as ultrasound and electrical stimulation, iontophoresis, etc.

I understand that no guarantees have been or can be provided regarding the success of therapy. I hereby request and consents to the evaluation and treatment to be provided by the physical therapists and physical therapy assistants of Greenwood Physical Therapy.

Patient Name: _____ Date:_____

Patient Signature: _____

THANK YOU!

Greenwood Physical Therapy

Patient Name: _____ DOB: _____

GENERAL CONSENT AND ACKNOWLEDGEMENT

CONSENT FOR DIAGNOSIS, CARE AND TREATMENT

I understand and acknowledge that this General Consent and Acknowledgement applies to care and treatment I receive at Greenwood Physical Therapy.

I consent to and authorize the physical therapists and other health care providers who may be involved in my care to provide such diagnosis, care and treatment considered necessary for the care I am seeking or as may otherwise be advisable for my well being. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at Greenwood Physical Therapy. I understand that health care providers in training, including students, may be involved in my care and treatment and I consent to their involvement in my care. I understand that if I leave the practice without the consent of the physician and/or fail to carry out instructions for follow-up care; I do so at my own responsibility. I further understand that any injury or harm I may suffer while away from Greenwood Physical Therapy will be my responsibility.

_____ Initial

USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that Greenwood Physical Therapy will use and disclose my health information for the purposes of treatment, payment, and healthcare operations. I understand, acknowledge and consent to the release of my personal health information for the purposes outlined in this section, as described in the Notice of Privacy Practices which has been offered to me, and as may otherwise be permitted by law.

_____ Initial

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Greenwood Physical Therapy's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I may request a copy of any amended Notice of Privacy Practices at each appointment. In accordance with the policy there will be no electronic devices allowed in the gym area. I understand the information Greenwood Physical Therapy acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the notice or as authorized by me in writing.

_____ Initial

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Greenwood Physical Therapy

Patient Name: _____ DOB: _____

CANCELLATION AND NO SHOW POLICY

Your physician has recommended physical therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments. Your therapist will advise you at your evaluation how many times a week it will be necessary for you to attend. ALL appointments missed MUST be made up in the same week so you may fully recover. Greenwood Physical Therapy requires 24 hours notice for any cancellation. If you do not give 24 hour advance notice for any cancellation or you do not show for your scheduled appointment an administrative fee of $25 will be billed to you.

_____ Initial

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT

I guarantee payment of all charges incurred for services rendered by Greenwood Physical Therapy for the patient name on the top of the page. I guarantee the amount due for non-insurable charges including co-payment, deductibles, etc. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover my treatment, I authorize Greenwood Physical Therapy to bill any such insurer for all charges incurred by me in connection with my diagnosis, care and treatment. I, as the responsible party, agree to furnish Greenwood Physical Therapy with up-to-date insurance. Any changes in insurance coverage must be reported to the office immediately. If my insurance plan requires a referral for me to come to Greenwood Physical Therapy, I understand that I am responsible for securing that referral. I further acknowledge that failure to do so may mean that I will not be seen upon arrival at the office. Acceptable methods of payment are cash, check or any card except AMEX.

_____ Initial

_____ _____

Signature of Patient or Responsible Party if Minor *Date*

_____

Please print name of patient

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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.

Greenwood Physical Therapy

Patient Name: _____
Date of Birth: _____
MRN: _____
Date of Service: _____
Physician: _____

Incontinence Impact Questionnaire, Short Form (IIQ-7)

Some people find that accidental urine loss may affect their activities, relationships, and feelings. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage over the past month.

Has urine leakage (incontinence) affected your:

	Not at All	Slightly	Moderately	Greatly
Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
Entertaining activities (movies, concerts, etc.)?	0	1	2	3
Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
Participation in social activities outside your home?	0	1	2	3
Emotional health (nervousness, depression, etc.)?	0	1	2	3
Feeling frustrated?	0	1	2	3

Adapted from Uebersax JS, Wyman FF, Shumaker SA, et al. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and urogenital distress inventory. Neurourol Urodyn 1995; 14: 131.