FOLSOM PHYSICAL THERAPY
and Training Center
Since 1983

INFORMATION ON TREATMENT FOR PELVIC FLOOR DYSFUNCTION AND BLADDER / BOWEL PROBLEMS

IMPORTANT – READ IMMEDIATELY

Your first appointment will take 45 to 90 minutes so plan your time appropriately. Please arrive at least 15 minutes early to complete necessary paperwork.

Your appointment is scheduled for _____ a.m. /p.m. on _____.

Enclosed please find:

1. **HISTORY AND SCREENING QUESTIONNAIRES**

All forms must be completed prior to your first appointment.

- Incomplete information may delay insurance processing and authorization for subsequent treatment.
- Prior to your first appointment we recommend you check with your insurance company regarding coverage for treatment.

The office evaluation/treatment of your condition may include:

- Review of your history
- Measurement of your pelvic floor muscle function with biofeedback equipment. These instruments record your muscle activity and help evaluate and treat your pelvic floor muscles.
- Musculoskeletal and pelvic floor muscle exam.
- Exercise instruction for pelvic floor and other muscle groups as indicated.

Return visits for therapy will be scheduled at regular intervals to measure your progress and modify your exercise program as needed. These appointments are important in order to progress your treatment program.

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

If you have any questions, please telephone 916-355-8500.

115 Natoma Street, Folsom, California 95630
Phone (916) 355-8500 Fax (916) 355-8196

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INFORMED CONSENT FOR TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to the following: observation, palpation, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

Potential benefits: may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records: I authorize the release of my medical records to my physicians/primary care provider and/or insurance company.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapist of Folsom Physical Therapy.

Patient/Guardian Name (Please Print): _____ **Date**: _____

Patient/Guardian Signature: _____

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PLAN OF CARE AGREEMENT

My diagnosis, evaluation findings including the treatment program, the expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program, has all been explained to me. My questions about my care have been answered to my understanding and satisfaction.
I consent to the recommended course of treatment.

For optimum care and progress:

- It is important to keep your regularly scheduled therapy appointment. At those visits we can advance your exercise routine.
- Please avoid practicing your pelvic floor exercises just before your next appointment time.
- Bring your exercise sheets, voiding log and biofeedback internal sensors as appropriate to each office visit.

Patient Name (Please Print): _____ Date: _____

(Patient/Guardian) Signature: _____

Therapist Signature: _____

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PELVIC FLOOR PATIENT HISTORY

1. Describe the current problem that brought you here? _____
2. When did your problem first begin? Months ago or years ago. _____
3. Was your first episode of the problem related to a specific incident? Yes/No (Describe)

   _____
4. Since that time is it: staying the same getting worse getting better? _____ Why or how?

   _____
5. If pain is present rate pain on a 0-10 scale 10 being the worst. Describe the nature of the pain (i.e. constant burning, intermittent ache) _____
6. Describe previous treatment/exercises_____
7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

   ___ Sitting greater than minutes
   ___ Walking greater than minutes
   ___ Standing greater than minutes
   ___ Changing positions (i.e. - sit to stand)
   ___ Light activity (light housework)
   ___ Vigorous activity/exercise (run/weight lift/jump)
   ___ Sexual activity
   ___ Other, _____
   ___ With cough/sneeze/straining
   ___ With laughing/yelling
   ___ With lifting/bending
   ___ With cold weather
   ___ With triggers -running water/key in door
   ___ With nervousness/anxiety
   ___ No activity affects the problem
8. What relieves your symptoms?

   _____
9. How has your lifestyle/quality of life been altered/changed because of this problem?

   _____

   Social activities (exclude physical activities), specify _____

   Diet /Fluid intake, specify _____ Physical activity, specify _____

   Work, specify _____ other _____
10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____
11. What are your treatment goals/concerns? _____

Since the onset of your current symptoms have you had?

Y/N Fever/Chills Y/N Malaise (Unexplained tiredness) Y/N Unexplained weight change
Y/N Muscle weakness Y/N Dizziness or fainting Y/N Night pain/sweats
Y/N Change in bowel or bladder functions Y/N Numbness / Tingling Y/N Other_____

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Pg 2 History

Health History: Date of Last Physical Exam _____ Tests performed _____
_____
General Health: Excellent__ Good__ Average__ Fair__ Poor __ Occupation: _____
Hours/week: _____ on disability or leave? _____ Activity Restrictions?_____
Mental Health: Current level of stress: High Med Low Current Psych Therapy? Y/N
Activity/Exercise: None__ 1-2 days/week__ 3-4 days/week__ 5+ days/week____
Describe: _____

Have you ever had any of the following conditions or diagnoses? Circle all that apply /describe

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression Rheumatoid Arthritis	Hepatitis	HIV/AIDS
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe_____

Surgical /Procedure History

Y/N Surgery for your back/spine	Y/N Surgery for your bladder/prostate
Y/N Surgery for your brain	Y/N Surgery for your bones/joints
Y/N Surgery for your male/female organs	Y/N Surgery for your abdominal organs

Other/describe _____

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #_____	Y/N Vaginal dryness
Y/N Episiotomy #_____	Y/N Painful periods
Y/N C-Section #_____	Y/N Menopause - when?
Y/N Difficult childbirth #____	Y/N Painful vaginal penetration
Y/N Prolapse or organ falling out	Y/N Pelvic pain

Y/N Other /describe_____

Males only

Y/N Prostate disorders	Y/N Erectile dysfunction
Y/N Shy bladder	Y/N Painful ejaculation
Y/N Pelvic pain	

Y/N Other /describe _____

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Medications - pills, injection, patch	Start date	Reason for taking

Over the counter -Vitamins etc.	Start date	Reason for taking

Symptoms

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections
Y/N Other/describe _____

1. Frequency of urination: awake hour's _____ times per day, sleep hours_____ times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   ___ minutes, ____hours, ___ not at all
3. The usual amount of urine passed is: ___small ___ medium___ large.
4. Frequency of bowel movements _____times per day, _____ times per week, or _____.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
   ___minutes ____hours ____not at all.
6. If constipation is present describe management techniques: _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
   Of this total how many glasses are caffeinated? _____ glasses per day.

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8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present

___Times per month (specify if related to activity or your period)

___With standing for minutes or hours.

___With exertion or straining

___Other

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes

___ No leakage

___ Times per day

___ Times per week

___ Times per month

___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes

___ No leakage

___ Times per day

___ Times per week

___ Times per month

___ Only with exertion/strong urge

10a. On average, how much urine do you leak?

___ No leakage

___ Just a few drops

___Wets underwear

___Wets outerwear

___Wets the floor

10b. How much stool do you lose?

___ No leakage

___ Stool staining

___ Small amount in underwear

___ Complete emptying

11. What form of protection do you wear? (**Please complete only one**)

___None

___Minimal protection (Tissue paper/paper towel/pant shields)

___Moderate protection (absorbent product, maxi pad)

___Maximum protection (Specialty product/diaper)

___Other _____

On average, how many pad/protection changes are required in 24 hours? _____# of pads

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BLADDER HEALTH QUIZ

1. Do you urinate more than every two hours in the daytime? Y / N
2. Do you urinate more than once after going to bed? Y / N
3. Do you have trouble making it to the toilet on time when you have an urge to go? Y / N
4. Do you strain to pass urine? Y / N
5. Do you rush to go to the toilet to empty your bladder? Y / N
6. Are you unable to stop the flow of urine when on the toilet? Y / N
7. Do you have an urge to go but when you get to the toilet very little urine comes out? Y / N
8. Do you lack the feeling that you need to go to the toilet? Y / N
9. Do you empty your bladder frequently, before you experience the urge to pass urine? Y / N
10. Do you have the feeling your bladder is still full after urinating? Y / N
11. Do you experience slow or hesitant urinary stream? Y / N
12. Do you have difficulty initiating the urine stream? Y / N
13. Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, key in the door) Y / N
14. Rate the following statement as it applies to you today.
My bladder is controlling my life. 0= not at all true 10 = completely true

0 1 2 3 4 5 6 7 8 9 10

If you answer yes to any of these questions you could benefit from conservative treatment for your bladder. Talk to your health care provider for a referral.

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CONSENT TO TREAT

Please circle Yes or No:

Were you injured on the job?	Yes	No
Have you filed a work comp. claim?	Yes	No
Were you involved in a Motor Vehicle Accident?	Yes	No
Is this injury involved in litigation?	Yes	No

*We DO NOT accept liens against pending legal settlements.

If you have an Attorney, please fill out the following:
Name of Attorney: _____
Phone: _____ Fax: _____
Address (include city, state & zip): _____

Have you had any Physical Therapy this year at another clinic?	Yes	No

If yes, how many visits? _____

Have you had any Chiropractic visits?	Yes	No

If yes, how many visits? _____

Missed Appointments:
Please notify us at least 24 hours in advance if you cannot keep your scheduled appointment in order for us to be able to fill your appointment time. Cancellations or missed appointments without 24 hour notice are subject to a charge equal to the amount of the appointment.

I, _____, have read and understand that I remain responsible for the total amount due to Folsom
(PRINT NAME HERE)
Physical Therapy for their services and policies, such as that listed above. I, the undersigned, do hereby agree and give my consent to Folsom Physical Therapy to furnish my medical care and treatment considered necessary and proper in assessing or treating my physical condition.

I hereby assign all medical benefits to Folsom Physical Therapy and authorize release of all information necessary to secure payment. A photocopy should be considered valid.

(Patient/Guardian)Signature_____ Date: _____

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FINANCIAL POLICY

Payment is due at the time of service unless special payment arrangements have been approved in advance by our staff. We accept cash, checks, major credit cards (Visa, MasterCard, etc.) We will be happy to process to your insurance claim for reimbursement. However, **it is the patient's responsibility to familiarize themselves with their own insurance policy and understand their terms and coverage thoroughly regarding physical therapy.**

The exact cost of our treatment is impossible to predict as the amount billed varies depending on services rendered at each visit. Reimbursements by insurance companies also vary and are predictably less than the billed amount.

In an attempt to help you understand your financial relationship with us, an estimate of the average cost of treatment is as follows:

	Average Billed Amount	Cash Pay Discount
Evaluation	$225.00	$150.00
Regular follow-up	$125.00	$85.00
Extended Follow-up	$200.00	$150.00

The cash pay discount can be applied if arrangements are made **prior** to initiating treatment and paid at the time service is rendered.

Please do not ask us to retroactively alter our business arrangement with you. Once your insurance has been billed it is very difficult to alter the process.

If you have a large deductible it may be in your best interest to have a cash pay arrangement with us. You may also be capable of submitting your receipts to your insurance company for full or partial reimbursement, or the amount paid applied to your deductible. Your ability to do so and the amount recognized by your insurance company will be dependent of your contract with them.

If you have any questions regarding the above information, please do not hesitate to ask us.

I, _____, have read and understand the Financial Policy as stated above.

(PRINT NAME HERE)

(Patient/Guardian)Signature_____ Date: _____

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PRIVACY PRACTICE

- This notice describes how medical information about you, the patient, may be used and disclosed. It also explains how you can get access to this information. **Please review it carefully**.

Our commitment here at ***Folsom Physical Therapy*** is to serve our patients with professionalism and care, while protecting the privacy and security of all Protected Health Information at all times.

During the course of serving your interests, it may be necessary to share information with other health care providers or business associates. Examples of such instances are described below:

- We may request from your physician MRI's, X-Rays, operation reports and other information that would be helpful in the course of your treatment.
- We use the services of an independent billing company, and so medical information will be passed along to them for billing and payment purposes.

We, here at ***Folsom Physical Therapy***, are committed to obeying all federal, state and local laws regarding privacy practices. If any other uses or disclosures other than those listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your protected health information, please contact our offic**e** at **(916) 355-8500**.

I, _____, have read and understand the above Notice of Privacy Practices.
(PRINT NAME HERE)

(Patient/Guardian) Signature: _____Date: _____

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MEDICAL RELEASE AUTHORIZATION

To Whom It May Concern:

I, _____, hereby give my consent for Folsom Physical Therapy to release my Protected
(PRINT NAME HERE)
Health Information (PHI) including physical therapy notes, dates of services, and diagnosis codes, to/from the following person(s)/facilities:

_____, M.D. Effective dates: _____ - _____

This authorization may be revoked at any time by delivering a signed Restriction Request Form to our business office at Folsom Physical Therapy.

Sincerely,

(Patient/Guardian)Signature_____ Date: _____

APPOINTMENT REMINDER

I, _____, would like to receive __text/__email reminders regarding my scheduled
(PRINT NAME HERE)
appointments at Folsom Physical Therapy. I, the undersigned, give Folsom Physical Therapy permission to send my appointment information to me via text/email. I understand that standard text messaging rates will apply to me. I also understand that I cannot reply to the text/email reminders directly, and that I will need to call Folsom Physical Therapy in order to cancel or reschedule an appointment.

(Patient/Guardian)Signature_____ Date: _____

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