Satori Health and Wellness

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Patient Information Form—Pelvic

Date: _____

Last Name:_____ First Name:_____

Birth Date (DD/MM/YY):_____ Email (for appointment reminders):_____

Address:_____

City/Town:_____Province:_____Postal Code:_____

Home Ph:_____ Work Ph:_____ Cell:_____

Occupation:_____ Employer_____

Emergency contact:_____ Relationship:_____

Family Doctor:_____Phone:_____

Address:_____

How did you hear about us?:_____

Would you like a progress report regarding your treatment sent to your:

Family MD	Yes / No
Referring doctor	Yes / No_____
	Contact information for referring doctor

The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information, please feel free to ask. Your written permission is required to release any information, unless required by law.

Are you receiving treatment for other health care professionals? YES / NO (Please explain)

_____
_____
_____

 Name:_____ Date:_____

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
Please describe and specify date _____
_____
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 (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list _____

___ 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	Unexplained muscle weaknes
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 /describe_____		

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

Over the counter -vitamins etc	Start date	Reason for taking

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)

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 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_____		

Bladder / Bowel Habits / Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine
Y/N	Urinary intermittent /slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	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.
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/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
___Other _____

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

PELVIC FOOR CONSENT FOR EVALUATION AND TREATMENT

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 childbirth or 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, ligamentous tencion, 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, use of vaginal weights, 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.

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.

Cancellation Policy

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours business notice in advance, I will pay a cancellation fee equal to the fee for a treatment session.

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 an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by Laura Disenhaus, PT, DOMP.

Date:_____ **Patient Name (print):**_____

Patient Signature_____ **Parent/Guardian Signature**_____

Witness Signature_____