



3989 E Arapahoe Road, Suite 120
 Centennial, CO 80122
 303.740.2026 *phone, text*
 303.770.5459 *fax*
 www.ptspecialist.com

New Patient Form

PATIENT INFORMATION

Date

Legal Name (Last, First, MI) _____ Nickname _____ Date of Birth _____

Address _____ City, State, Zip code _____

Primary Phone _____ Email Address _____

Emergency Contact _____ Relationship _____ Phone _____

Sex: M F

Please note: Minors must be accompanied by a parent/guardian for the first visit to sign consent forms in person

PARENT/GUARDIAN

Name

Address _____ City, State, Zip code _____

Primary Phone _____

PHYSICIAN INFORMATION

In an effort to provide the highest quality health care for you, we would like to be able to communicate with your healthcare team. Please provide us with the names and phone numbers of any additional health practitioners involved in your care.

Primary Care Physician _____ Phone _____

Additional Healthcare Provider	_____	Type of Care	_____	Phone	_____
Additional Healthcare Provider	_____	Type of Care	_____	Phone	_____
Additional Healthcare Provider	_____	Type of Care	_____	Phone	_____

Who can we thank for referring you to Physical Therapy Specialists? _____

Internet: Google Facebook Yelp Other: _____



_____ (Initials) My insurance may reimburse me for services provided by Physical Therapy Specialists.
 I authorize Physical Therapy Specialists to mail/fax copies of my payments and progress notes, if necessary, to my insurance company for reimbursement.



3989 E Arapahoe Road, Suite 120
Centennial, CO 80122
303.740.2026 phone, text
303.770.5459 fax
www.ptspecialist.com

Physical Therapy Agreement of Policies

Please note that payment is made by the patient in full at the time of the appointment. Your insurance may offer benefits for out of network providers. As a courtesy, we can call to obtain your benefits for you. Just ask!

We are a non-participating provider for Medicare. Medicare subscribers also will pay at the time of service. We are still required to submit claims to Medicare and the reimbursements will be sent directly to you. Medicare will reimburse approximately 80% of the Medicare approved amount; your secondary insurance may also pay a portion according to the insurance plan details for physical therapy.

Fees are based on time spent with you and the treatments performed during your appointment. The fee ranges are as follows:

Initial Evaluation	\$215
60 Minute Visits	\$178
	(a \$7.00 charge for disposable medical supplies may be added for dry needling and biofeedback)

To maximize the enjoyment of your visit and in consideration of others, we ask you to carefully read and agree to the following policies:

PHYSICAL THERAPY POLICIES

- o Please be ready for your appointment at the scheduled time, arriving early if needed to use the restroom, schedule additional appointments, etc. Appointments MUST end at the time scheduled and cannot be extended.
- o If you arrive late to your scheduled appointment, you will be billed for the allotted time scheduled.
- o Please report any health issues, even minor injuries to your PT before your session begins.
- o Cell phones and pagers should be silenced.
- o Children must be supervised and cannot interrupt the therapy session. This is to maximize your therapy time. If at all possible, make other arrangements for your child.
- o Physical Therapy Specialists is not responsible for lost or stolen property.
- o Physical Therapy Specialists has the right to cancel an appointment the day of service due to family emergency, weather or illness. The appointment will be rescheduled for the next available time slot.

I have fully read, understand, and agree to follow the above policies.



Print Name

Signed

Date



3989 E Arapahoe Road, Suite 120
Centennial, CO 80122
303.740.2026 *phone, text*
303.770.5459 *fax*
www.ptspecialist.com

Conditions and Consent for Physical Therapy

COOPERATION WITH TREATMENT

I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. Late arrivals will be billed for the time scheduled. I agree to cooperate with and carry out the home physical therapy 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 physical 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.

INFORMED CONSENT FOR TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy 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 treatment and options available for my condition.

- **Potential Risks:** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.
- **Potential Benefits:** Benefits may include an improvement in my symptoms and an increase in my ability to perform 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 or insurance company.

FINANCIAL AND INSURANCE RESPONSIBILITIES

I agree to pay for my treatments at the time of service, by cash, check or credit card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time and obtain any pre-authorization that is necessary and get an estimate of my benefits. I understand that I will be provided with a paid receipt for services.

I understand that I am a patient of Physical Therapy Specialists, P.C., at 3989 E. Arapahoe Road, Suite 120, Centennial, CO, 80122. I agree to hold Physical Therapy Specialists harmless for any and all actions, causes of action claims, demands, damages, costs, loss of services, expenses, compensation, and all consequential damages and particularly on account of all injuries, both to my person and to my property, which have resulted or in the future may develop, or arise out of services and/or treatment. My care is the exclusive responsibility of Physical Therapy Specialists, P.C.

TELEHEALTH

Some patients may be eligible for treatments performed via telehealth, video conferencing. We use the teleconferencing platform PT Everywhere, which is HIPAA compliant with end to end secure encryption. Options for telehealth treatment may be discussed with your physical therapist.

I have read the above information and I consent to physical therapy evaluation and treatment.

Please be prepared to sign this consent for treatment at your first appointment.



3989 E Arapahoe Road, Suite 120
Centennial, CO 80122
303.740.2026 phone, text
303.770.5459 fax
www.ptspecialist.com

Cancellation and Missed Appointment Policy

Our goal is to provide quality, individualized physical therapy in a timely manner. “No-shows” and late cancellations inconvenience those individuals who need therapy. Following is our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of treatment.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of other patients on our waiting list, please be courteous and call the office promptly if you are unable to attend a scheduled appointment. Your appointment time will be reallocated to another patient in need of treatment. Appointments are in high demand and your early cancellation will give another patient the opportunity to have access to that appointment time.

If it is necessary to cancel your appointment, we require a call or text at least 48 hours in advance. Cancellations for Mondays must be received by the previous Friday by 5:00 pm. Two consecutive late cancellations or no-shows may warrant discharge from physical therapy.

HOW TO CANCEL AN APPOINTMENT

To cancel appointments please call or text **303-740-2026**. If you do not reach the office staff, you may leave a detailed message on voicemail. It is considered a late cancellation when a patient cancels their scheduled appointment without 48 hours advance notice.

If we do not receive 48 hours' notice, you will be charged a \$75.00 fee the first time and the cost of your last appointment the second time. Two consecutive late cancellations may warrant discharge from physical therapy.

NO SHOW POLICY

A “no-show” is someone who misses a scheduled appointment without notice. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a “no-show”.

For a “no-show” appointment, you will be charged a \$75.00 fee the first time and the cost of your last appointment the second time. Two consecutive no-shows may warrant discharge from physical therapy.

LATE ARRIVALS

In the event you are running late for your appointment, it is appreciated to call ahead to notify us of your expected late arrival. Please note that in order for us to accommodate other patients we will not be able to extend your appointment time and you will be charged the full amount for your visit.

Please take advantage of our Reminder Services. Appointment reminders can be delivered via text and email.

Please note: Exceptions will be made on a case by case basis.

I have read the policy above and agree to the terms.



Signature

Print Name

Date

Consent to Use and Disclosure of Health Information (HIPPA)

CONSENT AND DISCLOSURE

PHYSICAL THERAPY SPECIALISTS

By signing this form, you are granting consent to Physical Therapy Specialists to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices Guide provides more detailed information about our legal obligations to protect your health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at 303-740-2026. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.

By signing below, I acknowledge that Physical Therapy Specialists follows the "Notice of Health Information Privacy Practices" guideline as outlined in the Health Information Portability and Accountability Act (HIPPA).



Signed _____

Date _____

Communication Consent

COMMUNICATION

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's cell phone number instead of an individual's home phone number.

I wish to be contacted in the following manner (Check all that apply):

- Primary Phone: _____
 - OK to leave voicemail message with detail information
 - OK to leave message with a family member
 - Leave message with call back number only
- Secondary Phone: _____
 - OK to leave voicemail message with detailed information
 - OK to leave message with a family member
 - Leave message with call back number only

Written Communication:

- OK to email at this address: _____
- OK to mail to my home address



My preferred method of contact for appointment reminders is:

Text

Email

FUNCTIONAL DRY NEEDLING CONSENT FORM

Please read each item below and sign at the bottom. If you have any questions or need assistance with reading or completing this form, please inform us and we will be happy to help you.

Your physical therapist may utilize "functional dry needling" (FDN) in your treatment plan. Dry needling is a very effective treatment technique utilized in conjunction with other physical therapy interventions. FDN is used to treat neuro-myofascial dysfunction that can contribute to pain and impaired functional modality. FDN involves the use of a very fine solid filament sterile needle which is inserted into the skin and directly into a myofascial dysfunctional tissue trigger point. Movement of the needle without completely withdrawing it helps inactivate the trigger point, all of which may take approximately 5-10 seconds at each site. Your therapist may utilize stimulation or mechanical movement of the needle to treat the underlying dysfunction. No medication is used in FDN. Your physical therapist will not stimulate any distal or auricular points during dry needling.

Your physical therapist is professionally trained to perform FDN and has met all applicable competency requirements in FDN.

FDN should not be confused with traditional Chinese medicine or acupuncture treatment. A complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment. Other alternative therapies include soft tissue massage and mobilization.

The benefits of FDN include pain control/reduction, improvement in range of motion and mobility, improvement in muscle strength and function, and improvement in overall functional ability of the involved areas being treated. Our current charge for dry needling is \$7.00.

Potential risks of dry needling and steps to minimize or treat these risks include:

Pneumothorax (air between the lung and chest wall). When a needle slips along the side of a rib or penetrates further than anticipated, the pleural lining can be compromised and cause a pneumothorax. This is avoided by using techniques to "bracket" the needle with a bony backdrop to stop the needle progressing into the pleural cavity.

- ❖ Your physical therapist will utilize extra care and safety precautions when needling muscles near the lungs to minimize the chances of this complication. Symptoms of pneumothorax may include difficulty breathing or shortness of breath, tightness in the chest, fatigue and increased heart rate. ***If you experience any of these symptoms at any time after a treatment session, proceed promptly to an emergency facility and inform them that you have been treated with dry needling.***
- ❖ **Nerve Injury.** FDN poses a risk of nerve injury. Your physical therapist will avoid injury to any nerves by thoroughly palpating anatomical landmarks and avoiding common neural pathways. In the event that a nerve is contacted, temporary paresthesia (a prickling or tingling sensation) may result. This is usually brief and sometimes only present at the moment the nerve is stimulated. If sufficiently irritated this sensation may last for a few days but should fully resolve.

- ❖ **Temporarily increased pain, soreness, or aching.** You may experience these symptoms in the area(s) treated with FDN for one to three days following treatment. These symptoms may be minimized by applying heat and resting from excessive use of the area. Your physical therapist also may recommend certain stretching and movements to alleviate these symptoms.
- ❖ **Infection.** Anytime the skin is penetrated a risk of infection is present. We minimize this risk with the use of sterile needles and clean needle technique when performing FDN.
- ❖ **Bruising/bleeding.** During FDN, the needle may penetrate a blood vessel, which may cause a small amount of bleeding and possibly some bruising later. Your physical therapist will do their best to avoid penetrating any blood vessels and will utilize pressure to the site should this occur. The use of some medications that interfere with blood clotting may make this symptom more likely to occur. Please inform your physical therapist of any anticoagulant medication that you may be taking prior to receiving FDN.

Please consult with your practitioner if you have any questions regarding the above.

Please answer the following questions:

Are you immunocompromised? Yes No

Are you taking blood thinners: Yes No

Do you have any known disease/infection that can be transmitted through bodily fluids?

Yes No

Do you have any known allergies to metals? Yes No

For women, are you pregnant? Yes No If so how many weeks _____

If you marked yes to any of these questions please discuss with your practitioner.

I have reviewed the above information and understand the risks and benefits associated with dry needling. It is my desire to pursue treatment including dry needling and I give my consent.

You have the right to withdraw consent for this procedure at any time before it is performed.

Signature

Printed Name

Date

How to Determine Your Insurance Benefits for Physical Therapy

KEEP THIS WORKSHEET FOR YOUR RECORDS

1. Call the 1-800 # for customer service on your insurance card. Select the option that will allow you to speak with a customer service provider, not an automated system.
2. Ask the customer service provider to quote your physical therapy benefits in general. These are frequently termed rehab benefits and can include occupational therapy, speech therapy and sometimes massage therapy.
3. Make sure the customer service provider understands you are seeing a non-preferred provider/out-of-network provider.

WHAT YOU NEED TO KNOW

- ✓ Do you have an OUT-OF- NETWORK deductible? _____
If so, how much is it? _____
- ✓ How much of the deductible has already been met? _____
- ✓ What percentage of reimbursement do you have after the deductible is met? (60%, 80%, 90%, are all common)

- ✓ Does your policy require a written prescription from your primary care physician? _____
- ✓ Does your policy require pre-authorization or a referral on file for outpatient physical therapy services?

- ✓ How many physical therapy visits are allowed per year? _____
- ✓ Is the plan based on a calendar year?

- ✓ If not, what are the plan dates? _____

WHAT THIS INFORMATION MEANS:

- A deductible must be satisfied before the insurance company will pay for therapy treatment. We can provide forms and receipts for you to mail to your insurance company to help reach the deductible amount.
- If you have an office visit co-pay the insurance company will subtract that amount from the percentage they will pay. This will affect the amount of reimbursement you will receive.
- The reimbursement percentage will be based on your insurance company's established "reasonable and customary/fair price" for the service codes rendered. This price will not necessarily match the charges billed. Some may be less than you have paid.
- If your policy requires a prescription from your PCP, you must obtain one to send in with the claim. This is usually not difficult to obtain since your PCP sent you to a specialist for help with your condition. If the prescription from a MD or specialist is all you need, make sure to have a copy to include with your claim. Each time you receive an updated prescription you'll need to include it with the claim.
- If your policy requires pre-authorization or a referral on file and the insurance company doesn't have one listed yet, you'll need to call the referral coordinator at your PCP's office. Ask them to file a referral for your physical therapy treatment that is dated to cover your first physical therapy visit. Be aware that referrals and pre- authorizations have an expiration date and some set a visit limit. If you are approaching the expiration date or visit limit you'll need the referral coordinator at your doctor's office to submit a request for more treatment.

Patient History

NAME:	AGE:	DATE:
-------	------	-------

Previous PT? Yes No Previous PT for this issue? Yes No

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. Rate the severity of this problem from 0-10, with 10 being the worst:
6. If pain is present, rate pain on a 0-10, scale 10 being the worst:
7. Describe the nature of the pain (i.e. constant burning, intermittent ache): _____

7. Date of last physical exam: _____ Tests performed _____
8. Describe previous treatment/exercises: _____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities): _____
Diet/Fluid intake: _____
Physical activity: _____
Work, specify: _____
Other: _____
10. Activities/events that cause or aggravate your symptoms - check all that apply:

<input type="checkbox"/> Sitting longer than _____ minutes	<input type="checkbox"/> With cough/sneeze/straining
<input type="checkbox"/> Walking longer than _____ minutes	<input type="checkbox"/> With laughing/yelling
<input type="checkbox"/> Standing longer than _____ minutes	<input type="checkbox"/> With lifting/bending
<input type="checkbox"/> Changing positions (i.e. sit to stand)	<input type="checkbox"/> With cold weather
<input type="checkbox"/> Light activity (light housework)	<input type="checkbox"/> With triggers (running water/key in door)
<input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump)	<input type="checkbox"/> With nervousness/anxiety
<input type="checkbox"/> Sexual activity	<input type="checkbox"/> No activity affects the problem
<input type="checkbox"/> Other, please list _____	
11. What relieves your symptoms? _____

12. What are your treatment goals? _____

Since the onset of your current symptoms have you experienced:

- | | |
|---|--|
| <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Malaise (unexplained tiredness) |
| <input type="checkbox"/> Unexplained weight change | <input type="checkbox"/> Unexplained muscle weakness |
| <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Night pain/sweats |
| <input type="checkbox"/> Change in bowel or bladder functions | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Other/describe _____ | |

General Health: Excellent Good Average Fair Poor

Occupation _____

Hours/week _____ On disability or leave? Yes No Activity Restrictions? _____

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week

Describe: _____

Mental Health: Currently seeing a therapist? Yes No

Current level of stress: High Med Low

Have you ever had any of the following conditions or diagnoses?

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

Surgical/Procedure History:

- | | |
|--|--|
| <input type="checkbox"/> Surgery for your back/spine | <input type="checkbox"/> Surgery for your bladder/prostate |
| <input type="checkbox"/> Surgery for your brain | <input type="checkbox"/> Surgery for your bones/joints |
| <input type="checkbox"/> Surgery for your female/male organs | <input type="checkbox"/> Surgery for your abdominal organs |
| <input type="checkbox"/> Other/describe _____ | |

Obstetrics/Gynecology History (females only):

- | | |
|--|--|
| <input type="checkbox"/> Childbirth vaginal deliveries # _____ | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Episiotomy # _____ | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> C-section # _____ | <input type="checkbox"/> Menopause (age): _____ |
| <input type="checkbox"/> Difficult childbirth # _____ | <input type="checkbox"/> Painful vaginal penetration |
| <input type="checkbox"/> Prolapse or organ falling out | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Other/describe _____ | |

Males only:

- | | |
|---|---|
| <input type="checkbox"/> Prostate disorders | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Shy bladder | <input type="checkbox"/> Painful ejaculation |
| <input type="checkbox"/> Pelvic pain | |
| <input type="checkbox"/> Other/describe _____ | |

Medications

MEDICATIONS (PILLS, SHOT, PATCH)	START DATE	REASON FOR TAKING
OVER THE COUNTER (VITAMINS, ETC)	START DATE	REASON FOR TAKING

PELVIC SYMPTOM QUESTIONNAIRE

Bladder / Bowel Habits / Problems:

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

Frequency of urination

While awake: _____ times per day
 During sleep hours: _____ times per night

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

The usual amount of urine passed is: small medium large

Frequency of bowel movements:
 ___ times per day ___ times per week, or _____

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

If constipation is present, describe management techniques: _____

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

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

PELVIC SYMPTOM QUESTIONNAIRE CONTINUED

(skip the following if no leakage/incontinence occurs)

Bladder leakage – number of episodes

- No leakage
- ___ Times per day
- ___ Times per week
- ___ Times per month
- ___ Only with physical exertion/cough

Bowel leakage – number of episodes

- No leakage
- ___ Times per day
- ___ Times per week
- ___ Times per month
- ___ Only with physical exertion/cough

On average, how much urine do you leak?

- No leakage
- Just a few drops
- Wets underwear
- Wets the floor

How much stool do you lose?

- No leakage
- Stool staining
- Small amount in underwear
- Complete emptying

What form of protection do you wear? *(Please choose 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

PHYSICAL THERAPY EXPECTATIONS

We would like to determine your expectations for your physical therapy outcomes. In order to do so, please answer based on what you think will occur with your treatment versus what you would like to occur.

* At the end of physical therapy treatment, what do you expect will be the pain associated with your condition?
Worsen Stay the same Improve

* At the end of your physical therapy treatment, what do you expect will be your ability to perform a task you are currently unable to do (such as sit, walk, stand, clean house, play golf, etc.)?
Worsen Stay the same Improve