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## PELVIC FLOOR THERAPY QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home phone #: \_\_\_\_\_ Cellular #: \_\_\_\_\_ Work phone #: \_\_\_\_\_ Best # to call? Work / Home / Cell

Are you working? Yes/ No. If no, do you have a job to return to? Yes/ No. What is your occupation? \_\_\_\_\_

Briefly describe the history of your symptoms: \_\_\_\_\_

What exercise/sports/activities do you participate in? \_\_\_\_\_

What activities are you unable to participate in? \_\_\_\_\_

What would you like to do? What are your goals? \_\_\_\_\_

What MD's have you seen for this condition? \_\_\_\_\_

Any previous surgery for this condition? Yes \_\_\_ No \_\_\_ If Yes, what surgery did you have? \_\_\_\_\_

When? \_\_\_\_\_

Who was your surgeon? \_\_\_\_\_ What hospital? \_\_\_\_\_

List all previous other operations including dates: \_\_\_\_\_

### History

Answer with a Y (Yes) or N (No)

\_\_\_ Heart Disease \_\_\_ Cancer \_\_\_ Diabetes \_\_\_ Stroke \_\_\_ Pacemaker \_\_\_ Seizures

\_\_\_ Fainting Spells \_\_\_ High/Low blood pressure \_\_\_ Circulatory Condition \_\_\_ Hepatitis

\_\_\_ Bruise easily \_\_\_ Are you thirsty often? \_\_\_ Do you have shortness of breath?

\_\_\_ Thyroid condition \_\_\_ Kidney or liver disease \_\_\_ Pain or tightness in chest?

Number of pregnancies \_\_\_\_\_ Number of vaginal deliveries \_\_\_\_\_ Number of cesarean deliveries \_\_\_\_\_

Weight of largest baby \_\_\_\_\_ lb. Year last baby was born \_\_\_\_\_ Number of episiotomies \_\_\_\_\_

Did you have any trouble healing after delivery: Yes No

Do you have a history of sexual abuse or trauma: Yes No

Are you having regular periods/ menstrual cycles: Yes No N/A

Do you have frequent urinary tract infections: Yes No

Were you diagnosed with pelvic organ prolapse: Yes No

**Pain**

Do you have pain with:

Sexual intercourse:	Yes	No	
Pelvic exam:	Yes	No	
Tampon use:	Yes	No	
Back, leg, groin, abdominal pain:	Yes	No	Other: _____

Test results:

Urodynamics test	Yes	No	Results: _____
Cystoscope	Yes	No	Results: _____
Urine test	Yes	No	Results: _____
Bowel test	Yes	No	Results: _____

**Bladder symptoms**

Do you lose urine when you:

Cough / Sneeze / Laugh:	Yes	No	Lift / Exercise / Dance / Jump:	Yes	No
On the way to the bathroom:	Yes	No	Have a strong urge to urinate:	Yes	No
Hear running water:	Yes	No	Put the key in the door:	Yes	No
Other: _____	Yes	No			

Do you experience leaks Yes No If Yes, how often? \_\_\_\_\_ x / day / week / month

If Yes, how would you rate the size of the leak? Small Medium Large

Do you wear pads Yes No If Yes, how often? \_\_\_\_\_

Do you wet the bed Yes No

Have burning/ pain with urination Yes No

Difficulty starting a stream of urine Yes No

Strain to empty your bladder Yes No

Feel unable to empty bladder fully Yes No

Have a falling out feeling Yes No

Do you feel pressure in your abdomen Yes No

Have pain with a full bladder Yes No

Urinate more than 7 times/ day Yes No

Have an urgency to urinate Yes No

(a strong urge to urinate)

Feel the urge to urinate again after using the bathroom and pulling up your pants Yes No

**Bowel Symptoms**

Strain to have a bowel movement	Yes	No	Leak/ strain feces	Yes	No
Include fiber in your diet	Yes	No	Have diarrhea often	Yes	No
Take laxatives / enema regularly	Yes	No	Leak gas by accident	Yes	No
Have pain with bowel movement	Yes	No			
Have a very strong urge to move your bowels	Yes	No			
How often do you move your bowels: _____ per day / week					
Most common stool consistency					
_____ Liquid _____ Soft _____ Firm _____ Pellets _____ Other _____					

List all medications you are taking: \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Who is your family physician?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

May we send office notes: Yes \_\_\_\_\_ No \_\_\_\_\_

How did you learn about Metropolitan Physical Therapy?

Doctor/ Former Patient/ Friend/ Internet/ Yellow Pages/ Other

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**PATIENT RESPONSIBILITIES**

Metropolitan Physical Therapy will bill your insurance carrier at our contracted rates. You will be responsible for meeting your co-payments, deductibles or co-insurances after each visit, and please be aware of your insurance policy provisions. If we get denied payment for any reason due to provisions, you will be responsible to pay us for the denied visits. If you have any questions, please ask our billing department or contact your insurance directly. Once your insurance benefits are exhausted, if you wish to continue treatment, you will be responsible for our private fee. There will be an increase of fee if more than one diagnosis is being treated, additional equipment or multiple procedures are used. If this account shall be placed in the hands of an outside attorney for collection, the Responsible Party agrees to pay all costs of collection, including reasonable attorney's fees, not to exceed 20% of the unpaid balance, together with necessary court costs and disbursements. There will be a \$60 cancellation fee for appointments that are not cancelled 24 hours in advance. We also ask that if you are going to be late to your appointment, please call to notify us. We are trying our best to accommodate you and your schedule and in order to so we suggest that you book your appointments 4-6 weeks in advance so that you can get the time you want.

*I have read the above and agree to the Terms and Conditions. If under 18 please have a parent/guardian sign.*

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_