Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Symptoms

Y/N	Trouble initiating urine stream	Y/N	Blood in stool/feces
Y/N	Urinary intermittent /slow stream	Y/N	Painful bowel movements (BM)
Y/N	Strain or push to empty bladder	Y/N	Trouble feeling bowel urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Seepage/loss of BM without awareness
Y/N	Trouble emptying bladder completely	Y/N	Trouble controlling bowel urge
Y/N	Blood in urine	Y/N	Trouble holding back gas/feces
Y/N	Dribbling after urination	Y/N	Trouble emptying bowel completely
Y/N	Constant urine leakage	Y/N	Need to support/touch to complete BM
Y/N	Trouble feeling bladder urge/fullness	Y/N	Staining of underwear after BM
Y/N	Recurrent bladder infections	Y/N	Constipation/straining _____% of time
Y/N	Painful urination	Y/N	Current laxative use -type _____
Y/N	Other/describe _____		

Describe typical position for emptying: _____

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. The bowel movements typically are: watery __ loose __ formed__ pellets __ other _____
6. 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.
7. If constipation is present describe management techniques _____
8. 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.
9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

__None present
__Times per month (specify if related to activity or your menstrual period)
__With standing for _____ minutes or _____hours.
__With exertion or straining
__Other_____

10a. Bladder leakage - number of episodes
__ No leakage
__ Times per day
__ Times per week
__ Times per month
__ Only with physical exertion/cough

10b. Bowel leakage - number of episodes
__ No leakage
__ Times per day
__ Times per week
__ Times per month
__ Only with exertion/strong urge

11a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

11b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying
__ Other _____

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

__None
__Minimal protection (tissue paper/paper towel/pantishields)
__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

Kathe Wallace PHYSICAL THERAPY

ACKNOWLEDGEMENT RECEIPT
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

A.	I have received/read a copy of this office's Notice of Privacy Practices.	YES	NO	initial_____
B.	I agree to the open treatment area.	YES	NO	Initial_____
C.	I agree that PT/PTA students may participate in my physical therapy care.	YES	NO	Initial_____
D.	I agree that a private treatment area is not necessary.	YES	NO	Initial_____
E.	I agree that, due to this open format, unauthorized individuals may have the opportunity to learn of my protected health information.	YES	NO	Initial_____
F.	I agree that I must sign a sign-in sheet at each visit and I understand that subsequent visitors have opportunity to read my name.	YES	NO	Initial_____

X _____

Signature **Please Print Name** **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ **Individual refused to sign.**

_____ **Communication barriers prohibited obtaining the acknowledgement.**

_____ **Emergency situation prevented us from obtaining acknowledgement.**

_____ **Other (Please Specify)** _____

PERFORMANCE THERAPY

Thank you for choosing Performance Therapy. We look forward to helping you meet your rehabilitation needs. To help us serve you more efficiently, please read, sign, and date in the designated areas.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Performance Therapy to furnish medical care and treatment to _____ as considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian_____**Date**_____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned , do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Performance Therapy. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian_____**Date**_____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. Any unpaid balance after the first 30 calendar days of treatment accrues a 1.5% interest each month thereafter. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your Insurance Company. In the event your company established and internal usual and customary fee schedule, you will be responsible for the remaining difference.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Performance Therapy.

The above does not apply for those patients that are treated under VA or Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that my account if paid within 90 days of my discharge will be interest free, after 90 days my account will be subject to a 12% interest (APR). If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. Payments can be made in office or by mail with cash, check or credit/debit card. We accept Visa, Discover and Master Card.

Estimated Deductible & Visit Limit_____

Estimated patient payment/co-payment_____

Arrangement for payment of patient's share_____

NOTE: Estimated coverage, information is provided as a courtesy to our patient, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me.
I UNDERSTAND MY FULL RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

** A $50 charge will be given to cancellation when less than 24 hours notice is given**

Patient/Guardian/Responsible Party_____**Date**_____

Performance Therapy Representative/Witness_____**Date**_____