MendelsonKornblum
Physical Therapy & Rehabilitation
27472 Schoenherr Road / Suite 130 / Warren, MI 48044
P: 586-439-6243

Patient History

Name _____ **Age**_____ **Date**_____

1. Describe the current problem that brought you here?_____
_____

2. When did your problem first begin?
   a. _____ months ago
   b. _____ 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:
   a. _____ staying the same
   b. _____ getting worse
   c. _____ getting better

5. Describe the nature of the pain (i.e. constant burning, intermittent ache)_____
_____
_____

6. Describe any previous treatment/exercises to treat this condition:_____
_____
_____

7. Activities/events that cause or aggravate your symptoms. Check 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
_____ With nervousness/anxiety
_____ No activity affects the problem

Pain

For the following section, circle your pain on a 0-10 scale.

0 = No pain **10** = Worst pain **NA** = Not applicable

	0	1	2	3	4	5	6	7	8	9	10	NA
Pain with urination												
Burning with urination												
Pain in your rectum during a bowel movement												
Burning in your rectum during a bowel movement												
Throbbing in your rectum during a bowel movement												
Pain/discomfort when wiping self												
Pain when inserting a tampon												
Pain/ burning or discomfort in your clitoris												
Pain/ burning or discomfort in your vagina												
Pain/ burning or discomfort in your labia												
Pain/ burning or discomfort in your anus												
Pain in your belly / abdominal region												
Pain in your low back												
Pain your hip												
Painful periods												

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

0 1 2 3 4 5 6 7 8 9 10

Dyspareunia

Most women with dyspareunia complain of painful penetration at the opening of the vagina, they feel burning, stinging, ripping or pain. Others also feel pain with deeper penetration in the vagina, bladder, hips or back, still others say it feels like friction with thrusting. Do you have any of the following symptoms?

Dyspareunia is a medical term for painful penetration and is graded on 3 levels:

Level 1 is painful but with same frequency
Level 2 is painful and limits frequency
Level 3 is painful and prevents penetration

Do you have any of the following symptoms?

_____ Burning/ stinging, ripping or pain at the opening of the vagina
_____ Pain in vagina with deeper penetration
_____ Pain in the bladder with deeper penetration
_____ Pain in the hips with deeper penetration
_____ Pain in the back with deeper penetration
_____ Friction with thrusting

With penetration do you feel swollen, pressure or pain for days afterwards? Yes No

What do you do to make it feel better?

_____

_____

Can you reach orgasm? Yes No
Does it make the pain worse? Yes No

Has there ever been a time where you had sex without your consent? Yes No

What form of birth control do you use?

_____

_____

Health History:

Since the onset of your current symptoms have you had**:**

_____ Fever/Chills
_____ Unexplained weight change
_____ Dizziness or fainting
_____ Change in bowel or bladder functions
_____ Other /describe_____

_____ Malaise (Unexplained tiredness)
_____ Unexplained muscle weakness
_____ Night pain/sweats
_____ Numbness / Tingling

Date of Last Physical Exam _____
Tests performed_____
_____

Overall Health:

_____ Excellent
_____Good
_____ Average
_____ Fair
_____ Poor

Occupation _____
Hours worked/week: _____
On disability or leave? Yes No
Activity Restrictions? Yes No
If yes, what are your restrictions?
_____
_____

Mental Health:
Current level of stress:

_____High
_____ Medium
_____ Low

Are you currently in psych therapy? Yes No

Activity/Exercise:

_____None
_____ 1-2 days/week
_____ 3-4 days/week
_____ 5+ days/week

Describe type of exercise: _____
_____

Have you ever had any of the following conditions or diagnoses? Check all that apply

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

Other/Describe_____

Surgical /Procedure History

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

Other/describe_____

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #_____
Y/N Episiotomy #_____
Y/N C-Section #_____
Y/N Difficult childbirth #_____
Y/N Prolapse or organ falling out
Y/N Other /describe_____
Y/N Vaginal dryness
Y/N Menopause - when? __

Males only

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

_____

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

_____
_____
_____

Over the counter -vitamins etc	Start date	Reason for taking

Pelvic Symptom Questionnaire

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
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel urge
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:
   a. _____X's per day
   b. _____X's 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?
   a. _____ minutes
   b. _____ hours
   c. _____ not at all

3. The usual amount of urine passed is:
   a. _____ small
   b. _____ medium
   c. _____ large
4. Frequency of bowel movements
   a. _____ X's per day
   b. _____ X's per week
   c. _____ X's per month
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
   a. _____ minutes
   b. _____ hours
   c. _____ not at all
6. If constipation is present, describe management techniques _____
   _____

7. Average fluid intake (one glass is 8 oz. or one cup): _____ glasses/day
   a. Of this total how many glasses are caffeinated? _____ glasses/day

8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
    a. _____ None present
    b. _____ Times per month (specify if related to activity or your period)
    c. _____ With standing for _____ minutes or _____hours
    d. _____With exertion or straining
    e. _____Other

Skip questions (9-13) if no leakage/incontinence of bowel or bladder

9. Bladder leakage - number of episodes
    a. _____ No Leakage
    b. _____ X's per day
    c. _____ X's per week
    d. _____X's per month
    e. _____ Only with physical exertion / cough

10. Bowel Leakage – number of episodes
    a. _____ No Leakage
    b. _____ X's per day
    c. _____ X's per week
    d. _____X's per month
    e. _____ Only with physical exertion / strong urge

11. On average, how much urine do you leak?
    a. _____ No Leakage
    b. _____ Just a few drops
    c. _____ Wets underwear
    d. _____ wets the floor

12. How much stool do you lose?
    a. _____ No Leakage
    b. _____ Stool staining
    c. _____ Small amount in underwear
    d. _____ Complete emptying

13. What form of protection do you wear? (Please complete only one)
    a. _____ None
    b. _____ Minimal protection (Tissue paper/paper towel/pantishields)
    c. _____ Moderate protection (absorbent product, maxipad)
    d. _____Maximum protection (Specialty product/diaper)
    e. _____ Other _____

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

Patient's signature: _____ Date: _____

Therapist's signature: _____ Date: _____

MendelsonKornblum
Physical Therapy & Rehabilitation

Name: _____ Date: _____

Vulvar Pain Functional Questionnaire (V-Q)

These are statements about how your pelvic pain affects your everyday life. Please circle the statement that best describes your situation.

Key: 0 = No issues 1= Minimal issues 2 = Moderate issues 3= Severe issue

1. Because of my pelvic pain
   3 = I can't wear tight-fitting clothing like pantyhose that puts any pressure over my painful area.
   2 = I can wear closer fitting clothing as long as it only puts a little bit of pressure over my painful area.
   1 = I can wear whatever I like most of the time, but every now and then I feel pain caused by pressure from my clothing.
   0 = I can wear whatever I like; I never have pelvic pain because of clothing.

2. My pelvic pain
   3 = Gets worse when I walk, so I can only walk far enough to move around my house, no further
   2 = Gets worse when I walk. I can walk a short distance outside the house, but it is very painful to walk far enough to get a full load of groceries in a grocery store.
   1 = Gets a little worse when I walk. I can walk far enough to do my errands, like grocery shopping, but it would be very painful to walk longer distances for fun or exercise.
   0 = My pain does not get worse with walking; I can walk as far as I want to
   0 = I have a hard time walking because of another medical problems, but pelvic pain doesn't make it hard to walk.

3. My pelvic pain
   3 = Gets worse when I sit, so it hurts too much to sit any longer than 30 minutes at a time.
   2 = Gets worse when I sit. I can sit for longer than 30 minutes at a time, but it is so painful that it is difficult to do my job or sit long enough to watch a movie.
   1 = Occasionally gets worse when I sit, but most of the time sitting is comfortable.
   0 = My pain does not get worse with sitting, I can sit as long as I wanty to.
   0 = I have trouble sitting for very long because of another medical problem, but pelvic pain doesn't make it hard to sit.

4. Because of pain pills I take for my pelvic pain
    3 = I am sleeping and I have trouble concentrating at work or while I do housework.
    2 = I can concentrate just enough to do my work, but I can't do more, like go out in the evenings.
    1 = I can do all of my work, and go out in the evenings if I want, but I feel out of sorts.
    0 = I don't have any problems with the pills that I take for pelvic pain.
    0 = I don't take pain pills for my pelvic pain.

5. Because of my pelvic pain
    3 = I hurt very bad when I try to have a bowel movement, and it keeps hurting for at least 5 minutes after I am finished.
    2 = It hurts when I try to have a bowel movement, but the pain goes away when I am finished.
    1 = Most of the time it does not hurt when I have a bowel movement, but every now and then it does.
    0 = It never hurts from my pelvic pain when I have a bowel movement.

6. Because of my pelvic pain
    3 = I don't get together with my friends or go out to parties or events.
    2 = I only get together with my friends or go out to parties or events every now and then.
    1 = I usually will go out with friends or to events if I want to, but every now and then I don't because of the pain.
    0 = I get together with friends or go to events whenever I want, pelvic pain does not get in the way.

7. Because of my pelvic pain
    3 = I can't stand for the doctor to insert the speculum when I go to the gynecologist.
    2 = I can stand it when the doctor inserts the speculum if they are very careful, but most of the time it really hurts.
    1 = It usually doesn't hurt when the doctor inserts the speculum, but every now and then it does hurt.
    0 = It never hurts for the doctor to insert the speculum when I go to the gynecologist.

8. Because of my pelvic pain
    3 = I cannot use tampons at all, because they make my pain much worse.
    2 = I can only use tampons if I put them in very carefully.
    1 = It usually doesn't hurt to use tampons, but occasionally it does hurt.
    0 = It never hurts to use tampons.
    0 = This question doesn't apply to me, because I don't need to use tampons, or I wouldn't choose to use them whether they hurt or not.

9. Because of my pelvic pain
   3 = I can't let my partner put a finger or penis in my vagina during sex at all.
   2 = My partner can put a finger or penis in my vagina very carefully, but it still hurts.
   1 = It usually doesn't hurt if my partner puts a finger or penis in my vagina, but every now and then it does hurt.
   0 = It doesn't hurt to have my partner put a finger or penis in my vagina at all.
   0 = This question does not apply to me because I don't have a sexual partner.
   0 = Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.

10. Because of my pelvic pain
   3 = It hurts too much for my partner to touch me sexually even if the touching doesn't go in my vagina.
   2 = My partner can touch me sexually outside my vagina if we are very careful.
   1 = It doesn't usually hurt for my partner to touch me sexually outside the vagina, but every now and then it does hurt.
   0 = It never hurts for my partner to touch me sexually outside the vagina.
   0 = This question does not apply to me because I don't have a sexual partner.
   0 = Specifically, I wont get involved with a partner because I worry about pelvic pain during sex.

11. Because of my pelvic pain
   3 = It is too painful to touch myself for sexual pleasure
   2 = I can touch myself for sexual pleasure if I am very careful
   1 = It usually doesn't hurt to touch myself for sexual pleasure, but every now and then it does hurt.
   0 = It never hurts to touch myself for sexual pleasure.
   0 = I don't touch myself for sexual pleasure, but that is by choice, not because of pelvic pain.

Total: _____/33

Patient's signature: _____ Date: _____

Therapist's signature: _____ Date: _____

EET

Name: _____

Birth date: _____

Home Address: _____

Phone Number:

Home: _____

Work: _____

Cell: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

PHYSICAL THERAPY APPOINTMENT ATTENDANCE POLICY

Consistent attendance to physical therapy is an important component of your rehabilitation process. However, if you should need to cancel or reschedule an appointment, please call us at 586-439-6243.

- I have read the above information and am aware that if I miss three consecutive appointments without prior notification, I can be removed from the schedule, with all future appointments cancelled. _____Please Initial
- Please give us at least 48 hours notice before cancelling an appointment. _____Please Initial
- Please be aware that if you show up 10 minutes late for an appointment can lead to the cancellation of that appointment. _____Please Initial
- Please be aware that it is your responsibility to verify your insurance coverage including deductable, co-payments and total annual benefits. _____Please Initial

PATIENT SIGNATURE: _____**Date:**_____

MENDELSON KORNBLUM
orthopedic & spine surgeons

General Consent to Outpatient Treatment

I request and authorize physician office, clinic, or outpatient care as my physician, his assistants or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians, and that other personnel render care and services to me (the patient) according to the physicians' instructions.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.

I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostics procedures. I authorize the facility to perform other tests on these body fluids and/or tissues in order to further medical research and knowledge and/or to dispose of these fluids and tissues.

I have been informed and understand that HIV (human immunodeficiency virus)/AIDS and HBV (hepatitis B virus) test may be performed on me without my consent if a health professional, facility employee or First Responder sustains an exposure to my blood or other body fluid.

ASSIGNMENT OF INSURANCE BENEFITS
Medicare Certification: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to the facility benefits otherwise payable to me. **I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.**

PERSONAL VALUABLES
I understand that I (the patient) am responsible for any and all personal valuables that I bring with me to the facility, clinic or physician's office. I hereby release the facility, clinic or physician's office from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

TEACHING INSTITUTION
I have been informed and understand that this facility is affiliated with a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize residents and/or students to participate in my care.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES
The Mendelson/Kornblum Notice of Privacy Practices provides information about how protected health information about me (the patient) - including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any) - may be used and disclosed. I have been offered an opportunity to review the Notice before signing the consent. I understand that the terms of the Notice may change.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction, but if they agree they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the Mendelson/Kornblum General Consent to Outpatient Treatment and Notice of Patient Rights and Responsibilities.

Name of Patient (print)_____

Signature of Patient_____

Date_____ Time_____

Signature of Spouse_____

Date_____ Time_____

Signature of Witness_____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative_____

Date_____ Time_____

Relationship_____

Address_____

Phone_____

Signature of Witness_____