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. Circle your pain on a 0-10 scale with 0 being no pain 10 being the worst pain.

0 1 2 3 4 5 6 7 8 9 10

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

_____

_____

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

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

Health History:

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	_____ 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 pain
_____ Tailbone pain	_____Fibromyalgia	_____ Diabetes
_____ Alcoholism	_____ Drug Problem	_____Arthritic conditions
_____ Childhood bladder problems	_____ Kidney disease	_____ Stress fracture
_____ Irritable Bowel Syndrome	_____ Depression	_____HIV/AIDS
_____ Rheumatoid Arthritis	_____ Hepatitis	_____Raynaud's Disease
_____ Anorexia/bulimia	_____ Joint Replacement	_____Pelvic pain
_____ Sexually transmitted disease	_____ Smoking history	_____ Neck pain
_____ Hearing loss/problems	_____ Physical/Sexual abuse	_____ Bone Fracture
_____ Vision/eye problems	_____ Sports Injuries	_____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 Painful periods
Y/N Menopause - when? _
Y/N Painful vaginal penetration
Y/N Pelvic pain

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 Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Other/describe_____
Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge
Y/N Current laxative use
Y/N Trouble feeling bowel urge
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections

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

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

MendelsonKornblum
Physical Therapy & Rehabilitation

Name: _____ **Date:** _____

Pelvic Floor Distress Inventory Questionnaire – Short Form 20

Please answer all of the questions in the following survey. These questions will ask if you have certain bowel, bladder, or pelvic symptoms and how much they bother you. Answer each question by circling the number in appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months.**

Do you usually experience pressure in the lower abdomen?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually experience heaviness or dullness in the lower abdomen?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually have a bulge or something falling out that you can see of feel in the vaginal area?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually experience a feeling of incomplete bladder emptying?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you feel the need to strain too hard to have a bowel movement?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you lose stool beyond your control if your stool is well formed?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually lose stool beyond your control if your stool is loose or liquid?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit

Do you usually lose gas from the rectum beyond your control?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually have pain when you pass your stool?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually experience frequent urination?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go the bathroom?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually experience urine leakage related to laughing, coughing or sneezing?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually experience small amounts or urine leakage? (That is, drops)	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually experience difficulty emptying your bladder?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit
Do you usually experience pain or discomfort in the lower abdomen or genital region?	0 Not at all	1 Somewhat	2 Moderately	3 Quite a bit

Total Score: _____/60

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_____

Dear Patient:

Hello and Welcome to Mendelson Kornblum Physical Therapy. The entire staff would like to *Thank You for choosing Us to be Your Therapy Team.* We assure you that we are dedicated to helping you achieve your goals.

To receive the best therapy experience and optimum results, please **Read** the following **Attendance Policies** and **Recommendations**.

Attendance Policies:

- Please arrive 15 minutes prior to your Initial Evaluation and Re-Evaluations in order to fill out proper documentations. Please have photo ID, insurance card and list of current medications.
- If you are unable to keep your scheduled appointment, please call us 24 hours prior to the scheduled time so that arrangements can be made to reschedule your appointment. Our number is **586-439-6243.**
- *PLEASE NOTE* : 3 No Shows in a row can result in a discharge from therapy. No Shows are considered scheduled appointments that are not kept without prior notification.
- Please arrive on time for your scheduled appointments. If you are going to be late for your scheduled appointment please call. We will do our best to accommodate you, but please keep in mind it may be with a different therapist.

Clothing Recommendations:

- Please wear loose-fitting, comfortable clothing that are comfortable for exercise and that will allow us to access to the area of treatment.
- Please wear appropriate shoes for physical activity.

Your treatment may include some, or all of the following:

- Therapeutic exercise/activities: Performed for strengthening and/or improving mobility or gait
- Manual Therapy: Including joint mobilization techniques, soft tissue massage and myofascial release.
- Modalities: Which include but not limited to hot packs, cold packs, electric stimulation and ultrasound

We would again like to Thank You, and look forward to working with you to achieve your goals.

Sincerely,

The Staff of Mendelson Kornblum Physical Therapy