Casco Bay Physical Therapy
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Falmouth, ME 04105
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(207) 781-5542 (fax)
cascobaypt@maine.rr.com

Hello and Welcome!

Thank you for scheduling an appointment for physical therapy. My mission is to provide specialized physical therapy evaluation and one-on-one treatment in a practical and compassionate manner. I am excited to work with you on a path of rehabilitation.

Attached is a comprehensive pelvic floor questionnaire to help me fully understand your symptoms. If you are not sure how to answer a question, leave it blank. We will go through the questionnaire together during your initial evaluation. This packet also includes a general patient information sheet as well as an authorization to pay benefits to provider. Please print and complete all the pages and bring them to your PT evaluation.

Thank you,

Allison Poole, MPT

Patient History

Name: ____ DOB: _____/_____/_______ Age: ________yrs.
Date: ________________

Describe the current problem that brought you here?

When did your problem first begin?

Was your first episode of the problem related to a specific incident? Yes/No
If yes, please describe, include date:

Since that time is it (circle one): staying the same getting worse getting better
Why or how?

If pain is present, rate pain on a 0-10 scale (*10 being the worst):* ____________________
Describe the nature of the pain (i.e. constant burning, intermittent ache):

Describe previous treatment/exercises:

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
☐ With cough/sneeze/straining
☐ With laughing/yelling
☐ With lifting/bending
☐ With cold weather
☐ With triggers i.e. /key in door
☐ With nervousness/anxiety
☐ No activity affects the problem
☐ Other, please list ____

What makes your symptoms better?

How has your lifestyle/quality of life been altered/changed because of this problem?

____

Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____

What are your treatment goals/concerns?

Since the onset of your current symptoms have you had:

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder functions
Y/N Other /describe
Y/N Malaise (unexplained tiredness)
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness /tingling

Date of Last Physical Exam ___________
Tests performed:
____
____

General Health (please circle): Excellent Good Average Fair Poor
Occupation: ________________________________ Hours/week: ________
On disability or leave? Y / N Activity Restrictions?__________________________

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

Mental Health: Current level of stress: High Med Low Current psych therapy? Y/N

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

Over the counter -vitamins etc	Start date	Reason for taking
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________

Have you ever had any of the following conditions or diagnoses? (Circle 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/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Acid Reflux /Belching	Hepatitis
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe: ____

____

Surgical /Procedure History

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

Other/describe: ____

____

Ob/Gyn History

Y/N	Childbirth vaginal deliveries #_______	Y/N	Vaginal dryness
Y/N	Episiotomy # _______	Y/N	Painful periods
Y/N	C-Section # _______	Y/N	Menopause - when? _______
Y/N	Difficult childbirth #_______	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic/genital pain

Other /describe: ____

____

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	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	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
Y/N	Painful urination	Y/N	Current laxative use _________

Other/describe:____

Describe typical position for emptying:(sitting upright, forward, hovering, etc)________________________________

____

1. Frequency of urination: awake hours __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?
   not at all   1-3min   4-10min   10-20min   21-60min   >1hr
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? not at all   1-3min   4-10min   10-20min   21-60min   >1hr
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 water?________ Caffeinated?: __________ Carbonated?: __________
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

CASCO BAY PHYSICAL THERAPY

Patient Information Form Date: ____________________

Please print:

Name: ____________________________________ Referring Physician: ____________________
(First) **(Last)** **(M)**

Address: __________________________________ Primary Care Physician: ________________

City: ______________________________________ State: __________ Zip: _______________

Date of Birth: ______________________ Age: _______ Home Phone: ______________________

Place of Employment: ____________________________ Work Phone: ______________________

E–Mail Address: ________________________________ Cell Phone: _______________________

Gender: M F In case of emergency contact: ___________________ Phone: _______________

Reason for Referral: ____

Date of injury/onset: ____

Date of Surgery: ____

Work Related: Yes No Auto Accident: Yes No Other Accident: Yes No

Patient's Primary Insurance: _______________________________ Policy No: ________________
(Insurance Company Name)

Patient's Secondary Insurance: _____________________________ Policy No: ________________
(Insurance Company Name)

Have you been a patient of Casco Bay Physical Therapy before? Yes No

Are you presently receiving Home Health services such as nursing, IV therapy, etc? Yes No

Have you received speech therapy or physical therapy this year? Yes No

How did you hear about us? ❒ Doctor Recommended ❒ Family/Friend ❒ Website

❒ Phonebook ❒ Other: _______________________

Internal: Reviewed each year:

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:

I hereby assign payment directly to **Casco Bay Physical Therapy** benefits due to me for services rendered. I understand I am financially responsible for any balance remaining after payment of benefits according to my insurance policy.

SUPPLIES:

I understand that I am financially responsible for all and any supplies that are given to me during the course of my treatment. Payment will be due on the day supply is received.

MEDICARE PATIENTS:

I have been notified by **Casco Bay Physical Therapy** that Medicare only covers 80% of all approved charges after which I am personally and fully responsible for the remaining percentage co-payment along with my annual deductible (if it has not been met). As well I have been informed that Medicare has enforced a cap of $1,850.00 per year for physical therapy and speech therapy combined, after which I would be responsible for payment of services. Most medigap insurances will not continue to pay for services denied by Medicare.

CANCELLATIONS:

Please call 24 hours in advance to cancel your scheduled appointment; otherwise there will be a $35.00 fee to be paid at your next appointment. Thank you for your cooperation.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _______________________________, have received the **Notice of Privacy Practices** from **Casco Bay Physical Therapy.** This notice is dated ______________.

Patient Signature: _______________________________________ Date: ______________