MOBILITY FIT
PHYSICAL THERAPY

WOMEN'S HEALTH ~ CLIENT DEMOGRAPHICS

DEMOGRAPHICS

First Name_____ Last Name_____ MI_____

DOB____/____/____ Cell Number_____ Alt. Number_____

Address_____ City_____ State_____ ZIP Code_____

Social Security Number_____ Email Address_____

How did you hear about us?_____

EMPLOYMENT INFORMATION

Occupation_____

Employer_____Employer Phone Number_____

INSURANCE INFORMATION

Person Responsible for Payment (Subscriber)_____ DOB____/____/____

Address (If Different)_____ City_____ State____ ZIP Code_____

Cell Number_____ Social Security Number_____

Name of Insurance Provider_____ ID Number (As Appears on Card)_____

Group Number_____

EMERGENCY CONTACT INFO

Name of Contact_____ Relationship to Client_____

Cell Number_____ Home Number_____

The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the Mobility Fit Physical Therapy, LLC. I understand that I am financially responsible for any balance. I authorize MOBILITY FIT PHYSICAL THERAPY LLC or insurance company to release any information required to process my claims.

Client/Guardian Signature_____ Date____/____/____

MOBILITY FIT
PHYSICAL THERAPY

WOMEN'S HEALTH ~ Health History Questionnaire

Name_____ Today's Date____/____/____

HISTORY

Number of pregnancies: _____ Year of most recent birth: _____ Number of vaginal deliveries: _____

Number of cesarean deliveries: _____ Birth weight of baby(ies): _____ Currently Breastfeeding: Y or N

Forceps or Suction use: Y or N Amount of tearing with delivery: _____ (# of tears, grade of tearing)

Did you have any trouble healing after delivery? Y or N Are you currently using any hormones: Y or N

Do you have a history of sexual abuse or trauma? Y or N

Are you having regular periods/menstrual cycles? Y or N

Do you have frequent Urinary Tract Infections? Y or N

CURRENT PROBLEM

Describe the current problem. When did it begin?

_____

_____

Has the problem: Stayed the same? Getting better? Getting worse? (circle one)

Rate your pain on a scale from 1 (best) to 10 (worst): Best:_____ Worst:_____ Current:_____

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

_____

PAIN: Do you have pain with:

Sexual intercourse Y / N	Tampon use Y / N	Pelvic Exam Y / N
Back, Leg, Groin Y / N	External touch to genitals/perineum Y / N	Abdominal Pain Y / N
Sitting Y/ N	Bowel Movements Y / N	Prolonged Standing Y / N

What specific activities/exercises are you <u>unable</u> to perform?

_____

WOMEN'S HEALTH ~
Medical History Questionnaire

Please list all surgeries or illnesses for which you have been hospitalized or treated, including approximate date.

DATE: SURGERY/TREATMENT REASON

_____

_____

MEDICAL HISTORY (Please circle all that apply)

Alcohol Consumption
Angina/Chest Pain
Anorexia/Bulimia
Asthma
Bowel or Bladder Problems
Carpel Tunnel Syndrome
Cancer
Chest/Abdominal Surgery
Childhood Bladder Problems
Coronary Artery Disease
Concussion
Depression
Endometriosis
Fibromyalgia
Heart Disease
Hepatitis
High Blood Pressure
High Cholesterol
Hypoglycemia
Low Blood Pressure
Latex Sensitivity
Motor Vehicle Accident
Migraine/Headaches
Major Spinal Injury
MRSA
Nicotine or Drug use
Osteoarthritis
Osteoporosis
Pacemaker/Nitroglycerin
Poor Circulation/Raynaud's
Rheumatoid Arthritis
Seizures
Sacroiliac/Tailbone pain
Sexually Transmitted Diseases
Traumatic Brain Injury/
Type 2 Diabetes
Type 1 Diabetes
Fractures_____
_____
Other_____
_____
_____
Arterial Calcification
Kidney Conditions
Blood Clotting Issues: Factor V Leiden, Venous Thromboembolism, etc
Extremities with Dialysis Access
Acidosis
Sickle Cell Anemia/Trait
Extremity Infection
Tumor of Arm or Leg
Increased Intracranial Pressure
Medications/Supplements known to increase the rick of clotting
Severe Crushing Injuries
Vascular Surgery: Grafting, Revascularization, etc
Lymphectomies/Lymphatic Dysfunction
Endocrine Dysfunction: thyroid, etc

CURRENT MEDICATIONS |PURPOSE | DOSAGE **CURRENT MEDICATIONS |PURPOSE | DOSAGE**

_____ _____

_____ _____

_____ _____

MOBILITY FIT
PHYSICAL THERAPY

WOMEN'S HEALTH ~ Symptoms Questionnaire

BLADDER SYMPTOMS: (Please circle all that apply)

Do you lose urine when:

Cough / Sneeze / Laugh	On the way to the bathroom
Get up from chair	Lift / Exercise / Squat / Jump / Dance / Run
Bend forward	Hear water running
During sexual activity or orgasm	Other:_____

Do you:

Wet the bed	Have a strong urge to urinate
Have burning / pain with urination	Feel unable to empty bladder fully
Have a strong urge to urinate	Pain with full bladder
Urinate more than 8x's/day	Difficulty starting stream of urine
Difficulty stopping stream of urine	Blood in urine
Strain to empty bladder	
Have a "falling out" feeling / bulging out tissue in the vagina	

How often do you urinate during awake hours per day: (circle) 2-4x's 5-8x's 9-12x's 13+
How many times do you urinate during sleep hours per night:_____
When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? (circle) not at all minutes hours

BOWEL SYMPTOMS: (Please circle all that apply)

Do you:

Strain to have a bowel movement	Have pain with bowel movement
Have a strong urge to move your bowel	Have diarrhea often
Leak / stain feces	Leak gas by accident
Include fiber in your diet	Take laxatives / enema regularly
Constipation	

How often do you move your bowels:_____(per day) _____(per week)
Do you strain or have difficulty with bowel movements: Y or N

MOBILITY FIT
PHYSICAL THERAPY

WOMEN'S HEALTH ~ Pelvic Floor Distress Inventory

Patient Name: _____ **Date:** _____

PFDI- 20 Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the *last 3 months*.

The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptoms Present = YES, scale of bother:

1 = not at all *(experienced previously)*
2 = somewhat
3 = moderately
4 = quite a bit

Symptoms Not Present **0 = not present *(never experienced)***

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you...	No	Yes
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

TOTAL:_____

Colorectal-Anal Distress Inventory 8 (CRAD-8):

Do you...	No	Yes
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or	0	1 2 3 4

TOTAL:_____

MOBILITY FIT
PHYSICAL THERAPY

WOMEN'S HEALTH ~ Pelvic Floor Distress Inventory

Do you...	No	Yes
15. Usually experience frequent urination?	0	**1 2 3 4**
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	**1 2 3 4**
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	**1 2 3 4**
18. Usually experience small amounts of urine leakage (that is, drops)?	0	**1 2 3 4**
19. Usually experience difficulty emptying your bladder?	0	**1 2 3 4**
20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0	**1 2 3 4**

TOTAL:_____

FOR PHYSICAL THERAPIST USE ONLY (do not complete)

POPDI-6: Total scores = ____ divide by 6 = _____ x 25 = _____

CRADI-8 Total scores = ____ divide by 8 = _____ x 25 = _____

UDI-6 Total scores = ____ divide by 6 = ____ x 25 = ____

Add all scores for PFDI-20 score = _____

WOMEN'S HEALTH ~ Client Consent Form

I, the Client, or parent/guardian of the client, _____, do hereby voluntarily consent to such care encompassing evaluation procedures and medical treatments sought by myself and/or as ordered by a physical therapist from Mobility Fit Physical Therapy.

1.) I authorize the staff of Mobility Fit Physical Therapy to undertake such procedures and treatments as deemed appropriate to improve my condition.

2.) I understand that communication between Mobility Fit Staff and communication with it's clients is an important part of my rehabilitation. I authorize email/text communication.

3.) It is recognized that the at-home program I am given by Mobility Fit Physical Therapy is a necessary component to the improvement of my condition, and therefore my responsibility to carry out in order to make these improvements in a timely manner.

4.) I authorize that I am responsible for understanding my contract with my insurance provider and that I may be contacted by an employee of Mobility Fit Physical Therapy to discuss my Physical Therapy coverage.

5.) I hereby authorize Mobility Fit Physical Therapy to release medical information regarding myself and my current condition to my insurance company, as well as referring, consulting, treating physicians or other medical providers as needed to support continuity of care.

6.) I understand that I have the right to a full explanation of treatments and procedures. I understand that I have the right to refuse any treatment; but, in doing so, I also understand that the desired outcome of my treatment plan may be negatively affected.

7.) I consent to the use of still photography and/or video analysis as a component of my physical therapy services. These will be used as necessary for my plan of care, and I will be made aware when these photos or videos are being taken. I understand that these photo's and/or videos are an important component of monitoring my progress and treatment. (In the rehab gym, not during internal examinations/treatments)

8.) I give my permission to use any pictures and/or videos taken for purposes including but not limited to social media postings, publications, advertisements, educational material, or in any medium now known or later developed, including the internet. (In the rehab gym, not during internal examinations/treatments).

_____ ***I DO give my consent*** *to Mobility Fit Physical Therapy to use my name and likeness to promote the above mentioned. (Line 8)*
Initial

_____ ***I DO NOT give my consent*** *to Mobility Fit Physical Therapy to use my name and likeness to promote the above mentioned. (Line 8)*
Initial

10. I have fully read the above in its entirety and I fully understand and agree to its contents.

_____ _____

Print Name of Client Signature of Client Date

MOBILITY FIT PHYSICAL THERAPY

WOMEN'S HEALTH ~ Consent to evaluate & treat Pelvic Floor

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I am being seen by a Pelvic Health-trained Physical Therapist for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, spinal manipulation, dry needling, and educational instruction.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I have the option of bringing a second person (ie family member) present in the room during the procedure for my comfort and _____ choose _____ refuse this option.

_____ _____

Patient Name: Date:

_____ _____

Signature of Parent or Guardian (if applicable) Patient Signature Witness Signature

WOMEN'S HEALTH ~
Client Payment Agreement

Mobility Fit Physical Therapy strives to provide you with a clear understanding of your financial responsibility with respect to the medical services we provide. Please read our policies below and provide your signatures.

We will gladly contact your insurance company to obtain your current benefit coverage. However, that information can be used only as a guideline and does not guarantee medical benefits or payment.

_____ *Initial* I understand that it is ultimately my responsibility to know and understand my benefit coverage for Physical Therapy.

_____ *Initial* I understand that my insurance company will determine and pay for services according to my plan benefits

_____ *Initial* I understand it is my responsibility, and agree to; pay all co-pays, co-insurance, or deductibles at the time of service.

_____ *Initial* I understand that it is my responsibility to pay all balances for uncovered services within 30 days of my discharge from PT.

_____ *Initial* I authorize Mobility Fit Physical Therapy to release my medical information to insurance companies, medical billing employees, physicians, and all other parties that may be involved in my claim

_____ *Initial* I understand that there will be a $20 fee automatically charged to my account per bounced check.

I wish to accept the insurance submission option, thus allowing Mobility Fit PT to send all claims to the insurance company provided for processing.

_____ ____/____/____
Client Signature Date

I have fully read, understand, and agree to the above Mobility Fit PT payment requirements. I authorize Mobility Fit PT to release pertinent medical information related to my insurance.

_____
Print Name of Client

_____ ____/____/____
Client Signature (or responsible party if minor) Date

WOMEN'S HEALTH ~ Cancellation & no-show policy

Our goal is to provide a physical therapy experience far superior to any you have previously known or experienced. This means that you will be scheduling one-on-one sessions with one of our doctors of physical therapy. Each and every appointment space is important; therefore our no-show and late cancellation policies are in place in order to maximize the available offerings for our clients.

EFFECTIVE JULY 1, 2018

Cancellation Policy & No-Show Policy:

With the high demand for available slots, we require 24-hours advanced notice to cancel an appointment.

- Cancellations or a no-show with less than 24-hours notice will receive a charge to their account, as follows:
  - **$50 per appointment**
  - **Multiple late cancellations or no-shows may result is termination from therapy at Mobility Fit's discretion.**

Late Arrival Policy:

We value each and every one of our clients and we desire for everyone to receive the same high-level of care at each and every visit.

- **In order to ensure this high-level of care, should you arrive 15 minutes or later from your scheduled start time, we will need to reschedule that appointment for another day and a late cancellation fee may apply. Our Client Coordinators will reach out to you after 10 minutes to determine how to proceed.**

By signing below, I understand that should I no-show, late cancel, or arrive late my account will either be charged or payment will be collected at my next visit. I understand that this policy is to encourage my dedication to the process and to ensure success for all.

Client Signature: _____ Date: ____/____/____