



# MEN'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 \_\_\_\_/\_\_\_\_/\_\_\_\_



# MEN'S HEALTH ~ Health History Questionnaire

Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## HISTORY

Have you ever had a Urinary Tract Infection? Y or N

Do you have any history of Hernia? Y or N -> If yes, what type? \_\_\_\_\_ Surgery to repair? Y or N

Have you ever had a serious pelvic or abdominal injury or procedure? Y or N ->If yes, what? \_\_\_\_\_

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

Are you currently using any hormones: 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

Prostate Exam Y / N

Abdominal Pain Y / N

Back, Leg, Groin Y / N

External touch to genitals/perineum Y / N

Prolonged Standing Y / N

Sitting Y/ N

Bowel Movements Y / N

*What specific activities/exercises are you unable to perform?*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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

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




# MEN'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             |                                     |

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

## SEXUAL SYMPTOMS:

Are you able to achieve an erection without medication? Y or N

Are you able to achieve an erections WITH medication? Y or N

Have there been any changes in your erectile, ejaculatory, or other sexual function that you are concerned about? Y or N

Do you have pain associated with sexual function? Y or N ->If yes, on a scale of 0-10 please rate this pain at worst: \_\_\_\_\_



# MEN'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)

<i>Do you...</i>	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):

<i>Do you...</i>	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: \_\_\_\_\_



# MEN'S HEALTH ~ Pelvic Floor Distress Inventory

<i>Do you...</i>	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 <i>pain</i> or <i>discomfort</i> 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 = \_\_\_\_\_



# MEN'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).

\_\_\_\_\_  
Initial      ***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)

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



# MEN'S HEALTH ~

## MOBILITY FIT **Consent to evaluate & treat Pelvic Floor** PHYSICAL THERAPY

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### 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



# MEN'S HEALTH ~ Client Payment Agreement

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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.

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

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

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

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

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

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

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



# MEN'S HEALTH ~

## Cancellation & no-show policy

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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 in 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: \_\_\_\_/\_\_\_\_/\_\_\_\_