Oliver Physical Therapy, PLLC at
Achievement Therapy & Wellness
2504 Genesee St, Suite IB
Utica, NY 13502
(315) 765-0063
atwcny.com

Welcome to Physical Therapy Services for Pelvic Health Conditions

Achievement Therapy & Wellness is a multi-specialty center including physical therapy and a variety of health and wellness programs. Our mission is to positively impact the health and wellness of community members locally, nationally, and globally. We believe in paying it forward. A portion of all our proceeds supports people with disability locally, nationally, and globally, through our rehabilitation clinic in Haiti.

Our physical therapy services, provided through Oliver Physical Therapy, PLLC, specialize in the evaluation and treatment of a full range of musculoskeletal, neuromuscular, vestibular, and pelvic health conditions for our clients.

What to Expect at your First Appointment?

Your first visit will include a variety of tests and measures to determine the most appropriate treatment plan for your condition. Your first appointment will last approximately 60 minutes.

Important!

Bring this completed packet, your Photo ID, Insurance Card and List of Medications to your appointment.

Please arrive at least 15 minutes early to ensure all paperwork and authorizations are complete prior to your visit.

Patient Information

Name: ______________________________ Middle: _________________ Last: ______________ ☐ Male ☐ Female
Address: ____ Apt/Unit: ________
City: ____ State: ______________________ Zip: ____________
Home Phone: ________________________ Work: _________________________ Cell: _______________________
Email: ____
Date of Birth: _______/_______/_______ Age: ___________

Emergency Contact: ____ Phone #: _________________________
Relationship: ____

Are you receiving Home Care Services? Yes No
Are you receiving Chiropractor services? Yes No
Are you receiving Physical Therapy services at another facility? Yes No

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed
Employer: ____

Medical Doctor Information (Complete only if not on your physical therapy prescription)
Referring Physician: ____ Phone #: _____________________
Address: ____
City: ____ State: ______________ Zip: ______________________
Family Physician: ____ Phone #: ________________________

Consent for Treatment The patient/legal guardian authorizes ATW / Oliver Physical Therapy staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.
Initial here ______

Consent to Release Medical Information I authorize ATW / Oliver Physical Therapy Services to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and ____
Initial here ______

Cancellation/No Show Policy I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and affects other patients as well. Appointments missed without sufficient notice (less than 24 hours) will be charged a $25 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as patient.
Initial here ______

I hereby certify that I understand these rights I acknowledge that I have been informed of ATW/ Oliver Physical Therapy, PLLC's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information.
Initial here ______

I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.
Initial here ______

Signature (Patient/Legal Guardian): ____ **Date:** ____________

Medical History

PATIENT NAME: ____ DATE: __________________________

Please list all your past medical conditions and surgeries

____
____
____
____
____
____
____
____

Please list all your current medications and supplements

____
____
____
____
____
____
____
____

Please list recent Tests or Medical Imaging that you have had regarding this condition in the last year

____
____
____
____

Patient Symptom Survey

PATIENT NAME: ____ DATE: __________________________

What brings you here today? ____
____

When did your symptoms begin? ____

What were you doing when it came on? ____
____

Have you had any recent medication changes, falls or illnesses prior to this condition? No Yes, ____________________
____

Have you had any recent surgeries that may have contributed to this condition? No Yes, ______________________
____

What is your main problem or primary concern? ____
____

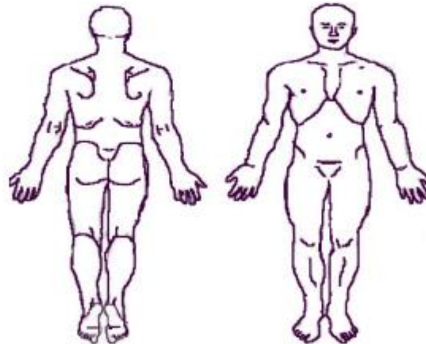
What was your level of function previously?

Independent with all activities or I had difficulty with some things such as ______________________________
____

Circle all the areas you have difficulty with?

Self-Care Changing Body Positions & Maintaining Body Position
Mobility: Walking & Moving Around Carrying, Moving & Handling Objects
Sleep Driving Work Social Activities Hobbies, Leisure, Sport Activities
Other: ____

Pain: Draw your pain on the body chart



Rate your pain on a scale of 0 -10 (0 being no pain - 5 being moderate pain - 10 being pain extreme pain)

At worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Pain Description: Circle all that apply:

Burning Sharp Dull/Achy Throbbing Shooting Numbness/Tingling Constant Intermittent
Worse in AM Worse in PM Worse at Night Other: ____

Circle all the things that aggravate this condition:

Sitting Standing Walking Stairs- up Stairs down Bending Voiding Lying Down Cough/Sneeze
Turning Rising AM As the Day progresses PM When still When on the move
Other: ____

Are your current Symptoms improving, worse or the same overall? ____

What are your goals of therapy? ____
____

Pelvic Health Patient Questionnaire (page 1)

PATIENT NAME: ___________________________________ DATE: ______________________

Please answer the questions regarding your history and symptoms to the best of your ability. Your therapist will review the answers with you at your appointment.

Briefly describe the reason for your appointment: ____

When did your problem first occur? ____

Tests and Test Results:

Have you had:

Urodynamics Test: Yes No Results: ____

Cystoscope: Yes No Results: ____

Urine Test: Yes No Results: ____

Bowel Test: Yes No Results: ____

Bladder Symptoms:

Do you lose urine when you cough, sneeze, or laugh? Yes No

Do you lose urine when you lift, exercise, dance, jump? Yes No

Do you lose urine on the way to the bathroom? Yes No

Do you lose urine when you hear running water? Yes No

Are there any other times when you lose your urine? ____

Do you wet the bed? Yes No

Do you have burning / pain with urination? Yes No

Do you have difficulty with starting a stream of urine? Yes No

Do you strain to empty your bladder? Yes No

Do you feel unable to empty full bladder? Yes No

Do you have a falling out feeling? Yes No

Do you have pain with a full bladder? Yes No

Do you have an urgency of urination (a strong urge to urinate) Yes No

Do you urinate more than 7 times per day? Yes No

Bladder leakage frequency: (circle)

Never Only with strong cough/sneeze Only premenstrual Constant

Per month _____ # Per week ______ # Per day _______

Severity of leakage: (circle)

No leakage Few drops Wets underwear Wets outwear

Protection worn: (circle one)

None Tissue paper/paper towel Panty shields

Mini pads Maxi pads Diaper

Specialty Product: ____

Pelvic Health Patient Questionnaire (page 2)

PATIENT NAME: ___________________________________ DATE: ______________________

Leakage Caused by: (circle ALL that apply)

Vigorous activity or exercise (running, weightlifting, etc) Light activity (walking, light housework)
Changing positions (sit to stand) Walking to the toilet Strong Urge to go
Intercourse or sexual activity No activity change leakage (constant despite activity)
Other: ____

Position or Activity with leakage: (Circle all that apply)

Lying Down Sitting Standing

How long can you delay the need the urinate? (Circle ONE)

Not at all 1-2 minutes 3-10 minutes 11-30 minutes 31-60 minutes ____ hours

Rate a feeling of "falling out" or pelvic heaviness/pressure:

None present ____ times per month Only with menstruation With standing
At the end of the day Present all day

Fluid Intake: (one glass is 8 oz or one cup)

____ glasses per day # of caffeinated glasses ____ per day # of alcoholic beverages ___ per day

Rate your feelings of the severity of the problem from 0-10 with 10 being the worst

0 1 2 3 4 5 6 7 8 9 10
Not a problem Major Problem

Rate the following statement as it applies to you today: My bladder is controlling my life.

0 1 2 3 4 5 6 7 8 9 10
Not a problem Completely True

Bladder Habits:

How often do you urinate during the day? _____ # of times
How often do you urinate after going to bed? ______# of times
Do you take your time to go to the toilet and empty your bladder? Yes No
Number of bladder infections in the last year? _______
Can you stop the flow of urine while on the toilet? Yes No
Is the volume of urine passes usually … Large Average Small Very small
Do you have the sensation that you need to go to the toilet? Yes No
Do you strain to pass urine? Yes No
Do you empty your bladder frequently, before you experience the urge to pass urine? Yes No
Do you have the feeling your bladder is full after urinating? Yes No
Do you have a slow or hesitant urinary stream? Yes No
Do you have difficulty initiating the urine stream? Yes No
Do you have triggers that make you feel like you can't wait to go to the toilet, like running water?
Yes No If yes, please list triggers: ____

Pelvic Health Patient Questionnaire (page 3)

PATIENT NAME: ___________________________________ DATE: _______________________

Bowel Symptoms:
Do you strain to have a bowel movement? Yes No
Do you include fiber in your diet? Yes No
Do you take laxatives / enema regularly? Yes No
Do you have pain with bowel movement? Yes No
Do you have a strong urge to move your bowels? Yes No
How often do you move your bowels? ______ times per day ______ per week
Your most common stool consistency is: (circle): liquid soft firm pellets other: ________________

Bowel Habits:
Frequency of bowel movements: ________ per day _______ per week
Consistency of stool: Loose______ Normal_______ Hard _______
History of constipation? Yes No
Do you currently strain to go? Yes No
Do you ignore the urge to defecate? Yes No
Do you have trouble making it to the toilet on time when you have the urge to go? Yes No

FOR MEN ONLY:
Have you ever had any form of prostate disease? Yes No _______________________________________

FOR WOMEN ONLY:
Have you ever had pelvic inflammatory disease? Yes No
Have you ever had endometriosis? Yes No
Have you ever had problems with your period? Yes No
Have you ever had complicated pregnancies / deliveries? Yes No
Are you pregnant or think you might be? Yes No
Number of pregnancies: ______________________
Number of vaginal deliveries: __________________
Number of cesarean deliveries: ________________
Birth weight of largest baby: __________________
Number of episiotomies: _____________________
Date of las pap smear: _______________________
Did you have any trouble healing after delivery? Yes No
Do you have history of sexual abuse or trauma? Yes No
Do you have frequent urinary tract infections? Yes No

Pain:
Do you have pain with sexual intercourse? Yes No
Do you have pain with pelvic exam? Yes No
Do you have pain with tampon use? Yes No
Do you have back, leg, groin, or abdominal pain? Yes No

Pelvic Floor Distress Inventory (page 1)

PATIENT NAME: ________________________________ **ID#:** ________________ **DATE:** ___________

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability.

Please circle the answers below that best apply

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

Pelvic Floor Distress Inventory Questionnaire - Short Form 20

			If yes, how much does it bother you?			
			Not at all	Somewhat	Moderately	Quite a bit
1.	Do you usually experience pressure in the lower abdomen?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
2.	Do you usually experience heaviness or dullness in the lower abdomen?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
3.	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
4.	Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
5.	Do you usually experience a feeling of incomplete bladder emptying?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
6.	Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
7.	Do you feel you need to strain too hard to have a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
8.	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
9.	Do you usually lose stool beyond your control if your stool is well formed?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
10.	Do you usually lose stool beyond your control if you stool is loose or liquid?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
11.	Do you usually lose gas from the rectum beyond your control?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)

Pelvic Floor Distress Inventory (page 2)

PATIENT NAME: ___________________________________ DATE: ______________________

			If yes, how much does it bother you?			
			Not at all	Somewhat	Moderately	Quite a bit
12.	Do you usually have pain when you pass your stool?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
13.	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
14.	Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
15.	Do you usually experience frequent urination?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
16.	Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
17.	Do you usually experience urine leakage related to laughing, coughing, or sneezing?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
18.	Do you usually experience small amounts of urine leakage (that is, drops)?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
19.	Do you usually experience difficulty emptying your bladder?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
20.	Do you usually experience pain of discomfort in the lower abdomen or genital region?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)

Therapist Only

ICD9 Code: ____________________________________

Comorbidities:

☐ Cancer ☐ Obesity ☐ Multiple Treatment Areas

☐ Diabetes ☐ Heart Condition ☐ Surgery for this Problem

☐ Fibromyalgia ☐ High Blood Pressure

Barber MD, Walters MD, Bump RC. Short forms of two condition-specific quality-of-life questionnaires for women with pelvic floor disorders (PFDI-20 adn PFIQ-7). Am J Obstet Gynecol 2005;193:103-113.

Pelvic Health Consent Form

GENERAL CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred to Oliver Physical Therapy, PLLC at Achievement Therapy & Wellness for evaluation and treatment of Pelvic Floor Dysfunction. I understand that to evaluate my condition, it may be necessary, initially, and periodically, to have my physical therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length. Palpation of these muscles is most direct and accessible if done via vagina and/or rectum.

Pelvic Floor dysfunctions include pelvic pain syndromes, urinary incontinence, fecal incontinence, dyspareunia, or pain with intercourse, pain from an episiotomy or scarring, vulvodynia, vestibulitis or other complications.

Evaluation and treatment may include, but not limited to the following: observation, palpation, use of vaginal cones or weights, vaginal or rectal sensors for biofeedback, exercise, soft tissue mobilization, joint mobilization, modalities such as electric stimulation or ultrasound, education, and neuromuscular techniques for the perineal area.

The therapist will explain all these treatment procedures to me, and I may choose not to participate with all or part of the treatment plan. While internal exam is most beneficial, external approaches can be provided to accommodate patient's comfort level. I understand that no guarantees have been or can be provided regarding the success of therapy.

I have read or had read to me the above and any questions have been answered to my satisfaction. I understand the risks, benefits, and alternatives of the treatment.

I hereby request and consent to evaluation and treatment to be provided by the physical therapists of Oliver Physical Therapy, PLLC at Achievement Therapy & Wellness.

Based on the information I have received; I voluntarily agree to standard assessment and muscular treatment techniques of the perineal area.

☐ I am comfortable with only the therapist performing the evaluation in the room.

☐ I would prefer to have a chaperone in the room while the therapist performs the evaluation.

Date: ____

Patient's Name (Please Print) ____

Patient's Signature: ____

Signature of Parent or Guardian if applicable: ____