



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**

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**Please list all your current medications and supplements**

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

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# 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, \_\_\_\_\_

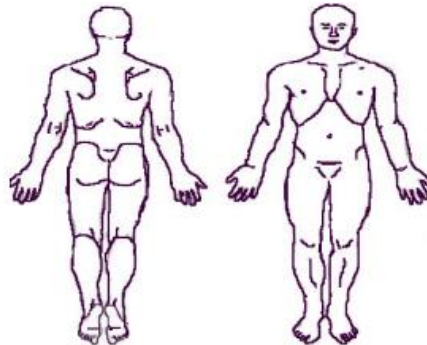
What is your main problem or primary concern? \_\_\_\_\_  
\_\_\_\_\_

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                             | Social Activities                                   |
| Driving                           | Hobbies, Leisure, Sport Activities                  |
| Work                              |   |
| 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

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, laugh, exercise, jump, dance? Yes No

Do you lose urine on the way to the bathroom? Yes No 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 or feel unable to empty your bladder? Yes No Do you have pain with a full bladder? 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: \_\_\_\_\_

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

If you have a feeling of "falling out" or pelvic heaviness/pressure, when do you have it:

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

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

\_\_\_\_\_ glasses of water # of caffeinated glasses \_\_\_\_\_ # of alcoholic beverages \_\_\_\_\_

**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

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

## Bowel Symptoms:

Do you include fiber in your diet? Yes No

Do you take anything to help with bowel movement i.e. laxative, enema Yes No

If Yes, what? \_\_\_\_\_

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:

History of constipation? Yes No If yes, how long? \_\_\_\_\_

Do you ignore the urge to defecate? Yes No

## FOR MEN ONLY:

Have you ever had any form of prostate disease? Yes No \_\_\_\_\_

If yes, please describe \_\_\_\_\_

## 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

If Yes, please describe \_\_\_\_\_

Have you ever had complicated pregnancies / deliveries? Yes No

If yes, please describe \_\_\_\_\_

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

If yes, please describe \_\_\_\_\_

Do you have frequent urinary tract infections? Yes No

Do you have history of sexual abuse or trauma? 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

If yes, please describe \_\_\_\_\_



# 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

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



# Pelvic Floor Distress Inventory (page 2)

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

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

**Therapist Only**

ICD9 Code: \_\_\_\_\_

Comorbidities:

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Obesity             | <input type="checkbox"/> Multiple Treatment Areas |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Surgery for this Problem |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> High Blood Pressure |   |





# 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.

### PELVIC HEALTH PROGRAM ETIQUETTE

Behavior: Any inappropriate comments and/or actions; before, during or after your therapy session will not be tolerated. It is solely up to the discretion of your therapist as to whether you will be permitted to schedule any additional appointments. This is a professional environment, and it shall be treated as such; no exceptions. Safety and comfort are top priorities, this applies to both the patient and the therapist. We reserve the right to refuse service to any person for any reason regarding inappropriate behavior.

Date: \_\_\_\_\_

Patient's Name (Please Print) \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Signature of Parent or Guardian if applicable: \_\_\_\_\_