405 E Marshall | Gilmer, TX 75644 | OFFICE: 903-402-1052 | FAX: 888-335-2090

625 Chase Dr. Suite 101 | Tyler, TX 75701 | OFFICE: 903-717-8966 | FAX: 903-630-1893

PATIENT NAME: FIRST_____MIDDLE_____LAST_____ SEX: [ ] M [ ] F or OTHER

DATE OF BIRTH: _____ MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ CELL #: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____ EMPLOYER NAME & PHONE:_____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

WHO MAY WE CALL IN CASE OF AN EMERGENCY: _____ PHONE: _____

Pelvic Floor Consent for Treatment and Attendance Agreement

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunction includes, but is not limited to urinary or fecal incontinence, difficulty with bowel, bladder or sexual function, painful scars after childbirth or surgery, sacroiliac disorders, low back pain, or pelvic pain.

I understand that to evaluate my condition, it may be necessary, initially or periodically, to have my therapist perform an internal pelvic floor exam. This is performed by observing and/or palpating digitally externally or internally the vagina or rectum and/or surrounding areas of the pelvic floor. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatments may include the following: observation, palpation, use of vaginal/rectal sensors, heat, cold, stretching, strengthening exercises, soft tissue massage or mobilization, and educational instructions.

I understand and agree that 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. I understand that if I do not show 2 appointments, I will be discharged from therapy services for non-compliance.

1. The purpose, risks, and benefits of pelvic floor physical therapy have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. **I understand that if I can not make my scheduled appointments, I will notify The Pelvic Fixx within 24 hours of my appt time**.

Patient Signature: _____ Date: _____

Staff Signature: _____

HIPAA – Release of Information

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination performed, treatment rendered to me, appointment scheduling, and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is **NOT** to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Contact by calling my:

[ ] Home: _____[ ] Cell: _____[ ] Work: _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____ between (time)_____

Legal Representative or Patient Signature: _____ Date: ____/____/____

PATIENT QUESTIONNAIRE: FEMALE PELVIC FLOOR

Name: _____ **Age:** _____ **DOB:** _____ **Weight:**_____ **Height:**_____

Primary Concern for Today's Visit: _____

Have you received previous Physical Therapy for this problem? (circle) No OR Yes: (date):_____

Have you received other treatment for this problem? No OR Yes: (type)_____

Medical History (circle all that apply): heart problems / hypertension / diabetes / cancer / osteoporosis
thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis
rheumatoid arthritis / seizures / history of stroke / kidney problems / depression / hx of blood clots/DVT
Other:_____

Surgical History (list type & date): _____

History of Trauma or Sexual Abuse:_____

Gynecological History (fill in blanks or circle answer for all that apply): Number miscarriages_____
Number of pregnancies_____ . Number of vaginal deliveries_____ . Number of C-sections_____
Birthdates & weight of each baby: _____
History of sexually transmitted diseases: No OR Yes: (specify active infections)_____
History of chronic urinary / bladder / yeast infections? No OR Yes: (specify)_____
Any active infections at this time? No OR Yes: (specify type/treatment)_____
Approximate date last menstrual cycle:_____ Menopausal? No OR Yes(hormone replacement?_____)
(Circle any that apply): Feelings of pelvic heaviness / history of: fibroids / cysts / endometriosis

Current Medications: _____

Allergies: _____

Work Status: ☐ currently working ☐ retired ☐ temporarily off work ☐ unemployed ☐ other:

Location / type of work: _____

Date of your next doctor's appointment: _____

Urinary Symptoms: Check all that apply and fill in appropriate blanks.

___ Urgency: abnormally strong urges to urinate
___ Frequency: urinates _____ times per (circle one) hour / day.
___ Leaking: When I leak, it (circle all that apply)
dampens underwear / dampens outerwear / empties my bladder completely.
___ Leaking: I leak with (circle all that apply): a strong urge to urinate / lifting / coughing
laughing / sneezing / bending / standing up / opening door to house / parking car
on way to bathroom / walking / jogging/exercise / sexual intercourse / hear running water
other:_____
___ Leaking: I leak _____ times a (circle one) day / week.

___ Use of leakage protection (number per day): panty liner____ / pad____ / diaper_____
___ Wake at night to urinate: number of times each night: _____
___ Burning with urination
___ Abnormal stream (specify:_____)
___ Difficulty or hesitancy with emptying bladder
Other:_____

Fluid Intake: Fill in *average number of cups* (1 cup=8 ounces) of each for a normal day:

___ Water	____ Milk	____ Juice (specify:_____)
___ Soft Drinks	____ Decaf Soft Drinks	____ Tea
___ Decaf Tea	____ Coffee	____ Decaf Coffee
___ Alcohol	____ Other:_____	

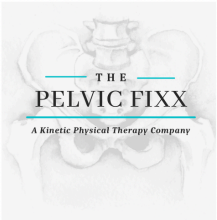
Bowel Symptoms: Check all that apply and fill in blanks.
Number of bowel movements per (circle one) day / week : _____
___ Constipation: I frequently strain to move bowels because of this: Yes OR No
___ Take regular fiber supplements (type and frequency):_____
___ Frequent diarrhea
___ Irritable bowel syndrome
___ Lactose intolerance or other food allergy affecting bowels (specify other: _____)
___ Bowel leakage (circle all that apply): stains underwear / small amount / large amount
___ Bowel leakage (circle all that apply): I leak with lifting / coughing / laughing / sneezing / bending / standing up / walking / jogging/exercise / sexual intercourse
other:_____
___ Bowel leakage: I leak _____ times a (circle one) day / week.
___ Use of leakage protection (number per day): panty liner____ / pad____ / diaper_____
Other: _____

Pain Symptoms:
Do you have pain? No OR Yes: location:_____
Do you have pain with Intercourse? Yes or No Explain:
Describe how the pain feels: _____
When did pain first begin: _____
Are any of your normal activities limited by pain? No OR Yes: (specify)_____
What makes your pain worse?:_____
Better?: _____
Rate your pain on the following scale: 0=no pain at all, 5=moderate pain, 10=worst pain imaginable
At worst (circle one): 0 1 2 3 4 5 6 7 8 9 10 On average: 0 1 2 3 4 5 6 7 8 9 10

Goals you want to achieve through therapy (be specific): _____

Questionnaire for Urinary Incontinence

	NONE	Rarely	Once in Awhile	Often	Most of the time	All the Time
Do you leak urine (even small drops), wet yourself, or wet your pads or undergarments...						
1. when you **cough** or **sneeze**?	□	□	□	□	□	□
2. when you **bend down** or **lift something up**?	□	□	□	□	□	□
3. when you **walk quickly, jog** or **exercise**?	□	□	□	□	□	□
4. while you are **undressing** in order to use the **toilet**?	□	□	□	□	□	□
5. Do you get such a **strong and uncomfortable need** to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?	□	□	□	□	□	□
6. Do you have to **rush to the bathroom** because you get a **sudden, strong need** to urinate?	□	□	□	□	□	□



CANCELLATION and NO SHOW POLICY

We have updated our Cancellation and No Show Policy. This will become effective on **February 1, 2025**.

By signing below, you authorize knowledge of this information and agree to comply with our policy.

Cancellation Policy:

I understand that a 24 hour notice **MUST** be given to The Pelvic Fixx either by email or phone. Calls received after 4 pm prior to the day before your appointment will not be answered until the next business day. Therefore, a voicemail must be left in order to comply with this policy. Cancellations less than 24 hours notice **will be charged a $50.00 fee** which will be collected prior to the next scheduled appointment.

No Show Policy:

I understand that if I No Show/No Call for my scheduled appointment, I will also be charged a **$50.00 fee**. **If I No Show/No Call 2 appointments, I give The Pelvic Fixx the authority to remove any future scheduled appointments and to discharge me from their care due to non-compliance of this policy.**

If you are more than 15 minutes late, The Pelvic Fixx reserves the right to refuse care due to limited availability and 1 hour time slots.

Your compliance with this policy only helps The Pelvic Fixx provide you with the best care possible in the most timely manner. Thank you for your understanding and we look forward to working with you!!!

_____ _____

Patient Name Date

_____ _____

Witness Date

Phone: Tyler - 903-717-8966 or Gilmer - 903-402-1052
Email: thepelvicfixx@gmail.com