Making Better Lives.
Rock Valley
PHYSICAL THERAPY

PATIENT HISTORY QUESTIONNAIRE - PT

Date _____

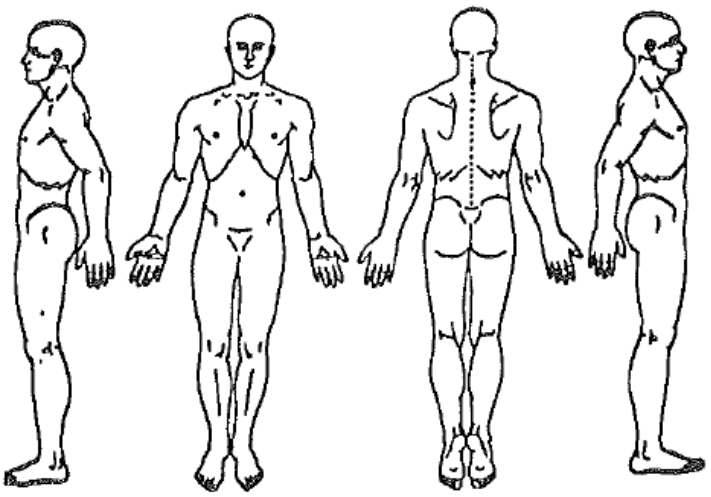
Name _____ DOB _____ Age _____ Height _____ Weight _____

Date of Next Visit with Referring Doctor _____ Family Doctor _____

Employer/Occupation _____ Leisure Activities _____

Describe the reason you are here _____

_____ Date Symptoms Began _____ Date of Surgery _____



Indicate on the diagrams, the area(s) or location(s) where you are currently experiencing symptoms, using the following key:

PPPPP = pins & needles
SSSSS = stabbing
XXXXX = burning
ZZZZZ = deep ache

Have you **EVER** been diagnosed as having any of the following conditions? Please circle.

Cancer	High Blood Pressure	Heart problems	Circulation problems	Blood Clots
Bleeding Disorder	Asthma	Hepatitis	Tuberculosis	Stomach Ulcers
Thyroid problems	Kidney problems	Depression	Diabetes	Multiple Sclerosis
Stroke	Seizures	Rheumatoid Arthritis	Chemical Dependency	
Osteoporosis	Osteoarthritis	COPD/Emphysema	Tobacco use: Y N Amt/day: _____	

Other _____

Please list any surgeries **or** other conditions for which you have been hospitalized, including the approximate date.

_____

Do you have allergies: Y N If yes, please specify _____

Please list any medications you are currently taking (prescription and over the counter). If you have a list, we would be happy to photocopy if for you.

_____

Please circle any of the following symptoms you are experiencing.

nausea/vomiting	fatigue	dizziness/lightheadedness	tremors
fever/chills/sweats	numbness or tingling	seizures	double vision
loss of vision	eye redness	skin rash	problems sleeping
sexual difficulties	hearing problems	joint/muscle swelling	easy bruising
excessive bleeding	difficulty breathing	regular cough	arm/leg swelling
heart racing in your chest	difficulty swallowing	heartburn/indigestion	post menopause
urinary incontinence	blood in urine	pregnant or think you might be	stress at home or work
weight loss/gain	bowel/bladder irregularities	abdominal pain/problems	
blood in stools	menstrual irregularities	night pain or night sweats	

If you circled any of the above, are you under a physician's care for this/these conditions? Y N

Patient Signature _____ *Thank you for taking time to complete this questionnaire.*

CARE CONNECTIONS

PELVIC FLOOR WORKSHEET

NAME _____ DATE _____

TIME _____ AM/PM ❒ Initial Visit ❒ Discharge Visit

CONDITION (CHECK ALL THAT APPLY)

❒ (A) Bladder incontinence
❒ (B) Urinary urgency/frequency
❒ (C) Bowel incontinence
❒ (D) Fecal urgency
❒ (E) Pelvic/perineal pain
❒ (F) Other

ACUITY (*Answer on initial visit.*)

How long ago did onset of symptoms occur? _____

FUNCTION

To what degree does your condition interfere with your participation in the following activities: (if you have bowel or bladder problems, rate interference when you are NOT using a pad or leakage protection).

	Never Interferes	10-20% of the time	30-40% of the time	50-60% of the time	70-80% of the time	Always Interferes
1. Household Activities	❒	❒	❒	❒	❒	❒
2. Physical Activity/Exercise	❒	❒	❒	❒	❒	❒
3. Intimate Relationships	❒	❒	❒	❒	❒	❒
4. Sitting through long events (more than 3 hours)	❒	❒	❒	❒	❒	❒
5. Work Activities	❒	❒	❒	❒	❒	❒
6. Activities without bathroom access	❒	❒	❒	❒	❒	❒
7. Travel	❒	❒	❒	❒	❒	❒
8. Sleep (# times/night your sleep is interrupted)	❒0×	❒1×	❒2×	❒3×	❒4×	❒5+×
9. Number absorbent products used per day to manage your condition	❒0×	❒1×	❒2×	❒3×	❒4×	❒5+×

10. PLEASE INDICATE TYPE OF PROTECTION USED

❒ (A) none
❒ (B) tissue/paper towels
❒ (C) panty liner
❒ (D) medium flow pad
❒ (E) heavy flow pad
❒ (F) specialty pad/protective garment

11. Number of bowel/urine leakage accidents per 24 hours? _____

12. Frequency of daytime urination? _____

13. Frequency of nighttime urination? _____

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain ——————————— Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)

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Date _____

PATIENT _____ **DOB** _____ Age _____
(FULL NAME, PLEASE DO NOT USE INITIALS)

Married ☐ Single ☐ Widowed ☐ Male ☐ Female ☐ **Soc. Sec. #** _____

Home Address _____

City _____ State _____ Zip Code _____ Home Phone _____ Cell _____

Email _____ ☐ I do not wish to receive the Rock Valley newsletter

Patient Employed by _____ Occupation _____

Business Address _____

City _____ State _____ Zip Code _____ Business Phone _____

Name of Spouse _____ **Soc. Sec. #** _____ **DOB** _____

Spouse Employed by _____ Business Phone _____

Emergency Contact _____ Phone _____

Relationship _____

IF PATIENT IS INSURED THROUGH A PARENT, COMPLETE THIS SECTION

FATHER: Name _____ **DOB** _____

Employer _____ Employer Phone _____

MOTHER: Name _____ **DOB** _____

Employer _____ Employer Phone _____

HOME ADDRESS OF PARENT(S) if different than patient's _____

_____ Phone _____

INSURANCE INFORMATION

Primary _____ Secondary _____

Is this a liability injury? Yes ☐ No ☐

If yes, please check one: Worker's Comp _____ Auto _____ Other _____

Claim#: _____ Contact Person _____ Phone _____

Are you being represented by an attorney? Yes ☐ No ☐

If yes:

Name _____ Phone _____

Address _____

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Welcome to Rock Valley Physical Therapy

Thank you for choosing Rock Valley and providing us the opportunity to work with you.
We hope to exceed your expectations and assist you in achieving your goals.

Notice of Privacy Practices:
I acknowledge receipt of Rock Valley's Notice of Privacy Practices. I have initialed here to indicate I am declining this notice _____.

Authorized Person(s):
I authorize you to speak to _____, _____ regarding my account and/or treatment.

Authorization to Release Information:
I authorize the release of any medical or any other information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or the benefits payable for related medical services and /or supplies provided to me by Rock Valley Physical Therapy.

Financial Responsibility:
I understand that insurance billing is a service provided as a courtesy and that I am, at all times, financially responsible to Rock Valley Physical Therapy. It is my responsibility to notify Rock Valley Physical Therapy of any changes in my health care coverage. I am responsible for the entire bill or balance of the bill as determined by Rock Valley Physical Therapy and/or my health care insurer if the submitted claims or any part of them are denied for payment. I request that payment of my services is made on my behalf to Rock Valley Physical Therapy. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services. I also understand that Rock Valley Physical Therapy collects for copayments at the time of service.

Supply Items:
I understand that Rock Valley Physical Therapy may, during the course of treatment, recommend purchase of a supply item. Supply items may or may not be covered under my insurance plan. I understand that it is my financial responsibility to pay for any item in full if it is not covered under my insurance plan.

This is to verify that I have read and agree with the above.

_____ _____
Patient or Responsible Party Date

Non-Discrimination Policy:

Rock Valley Physical Therapy does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact the administrative assistant at (309)-743-2070. TDD/Relay Iowa.

Pelvic Floor Distress Inventory					
Have you ever experienced any of the following:	No	If yes, how often?			
		Rarely (25% of the time)	Sometimes (50% of the time)	Frequently (75% of the time)	Always (100% of the time)
Pressure in the lower abdomen?					
Heaviness or dullness in the pelvic area?					
A bulge or something falling out that you can see or feel in the vaginal area?					
Having to push on the vagina or around the rectum to have or complete a bowel movement?					
A feeling of incomplete bladder emptying?					
Having to push up on a bulge in the vaginal area with your finger to start or complete urination?					
Needing to strain too hard to have a bowel movement?					
Feeling that you have not completely emptied your bowels at the end of the bowel movement?					
Losing stool beyond your control if your stool is well-formed?					
Losing stool beyond your control if your stool is loose or liquid?					
Losing gas from the rectum beyond your control?					
Pain when you pass your stool?					
A strong sense of urgency and have to rush to the bathroom to have a bowel movement?					
A part of your bowel passing through the rectum and bulge outside during or after a bowel movement?					
Frequent urination?					
Urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go the bathroom?					
Urine leakage related to coughing, sneezing or laughing?					
Small amounts of urine leakage (that is, drops)?					
Difficulty emptying your bladder?					
Pain or discomfort in the lower abdomen or genital region?					
Pain with intercourse?					

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Please complete a bladder log every day for 2 days and bring it to your appointment. Please do at least one day on a working day.

The main purpose of a bladder log is to document how your bladder functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns. At first, the log is used as an evaluation tool. Later, it will be used to measure your progress on bladder retraining or leakage episodes.

Your log will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of the day exactly what happened in the morning.

INSTRUCTIONS:

Column 1 – Time of Day

The log begins with midnight and covers a 24 hour period. Afternoon times are in **bold**. Select the hour block that corresponds with the time of day you are recording information.

Column 2 – Type & Amount of Fluid & Food Intake

- Record the type and amount of **fluid** you drank
- Record the type and amount of **food** you ate
- Record when you woke up for the day and the hour you went to sleep

Column 3 – Amount Voided (Urinated): Two methods

Record the time of day and the amount voided. Use the first method unless directed by your health care provider to directly measure or count urine amounts. Record a bowel movement with a BM at the appropriate time.

1. Place a S, M, L in the box at the corresponding time interval each time you urinate.
   S – SMALL = seemed like a small amount, or urinated "just in case".
   M – MEDIUM = seemed like 8 ounce measure cup would run over.
   L – LARGE = seemed like the amount you urinate when you first wake up in the morning
2. If you have difficulty gauging the amount of urine, you may record the seconds by counting "one-one thousand" (this equals one second) while emptying your bladder. Record the number of seconds it took you to void.

Column 4 – Amount of Leakage

Record the amount of urine loss at the time it occurred.

S – SMALL = drop or two of urine
M - MEDIUM = wet underwear
L – LARGE = wet outerwear or floor

Column 5 – Was Urge Present

Describe the urge sensation you had as:

1 – MILD = first sensation of need to go
2 – MODERATE = stronger sensation or need
3 – STRONG = need to get to a toilet, move aside!

Column 6 – Activity with Leakage

Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, bent over, lifted something or had strong urge.

Comments

At the bottom of the log table – Special problems and new or changes in medication are recorded here. If a pad change was needed, record the number used during the day at the bottom of the page.

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DAILY VOIDING LOG

Name ___**Sample**_____ **Date** ____**May 1, 2013**___

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided Ounces, S/ M/ L or Seconds	Amount of Leakage S/ M/ L	Was Urge Present 1/ 2/ 3	Activity with Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am	**Woke up at 6:45am**	**L**		**3**	
7:00 am	**Coffee, Bagel**				
8:00 am			**M**		**Fast Walking**
9:00 am	**Apple**	**M**		**2**	
10:00 am					
11:00 am					
NOON	**Tuna Sandwich, milk, pear**				
1:00 pm					
2:00 pm		**M**		**2**	
3:00 pm	**Tea, cookies**		**S**		**Running water**
4:00 pm					
5:00 pm					
6:00 pm	**Chicken, corn pudding, salad, apple juice**	**M**		**3**	
7:00 pm					
8:00 pm			**S**	**3**	
9:00 pm					
10:00 pm	**To bed at 10:30**	**M**		**3**	
11:00 pm					

Comments _____**week before period**_____
Number of pads used today _____**2**_____

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DAILY VOIDING LOG

Name _____ Date _____

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided Ounces, S/ M/ L or Seconds	Amount of Leakage S/ M/ L	Was Urge Present 1/ 2/ 3	Activity with Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
NOON					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments _____

Number of pads used today _____

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DAILY VOIDING LOG

Name _____ Date _____

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided Ounces, S/ M/ L or Seconds	Amount of Leakage S/ M/ L	Was Urge Present 1/ 2/ 3	Activity with Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
NOON					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments _____

Number of pads used today _____