

# MARATHON

## PHYSICAL THERAPY & SPORTS MEDICINE

www.MarathonPhysicalTherapy.com

Canton

Dedham

Easton

Newton

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### Pelvic Floor Physical Therapy Questionnaire

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Answering the following questions will help us to manage your care better.

Do you now have or have you had a history of the following?

- |     |  |     |   |
|-----|--|-----|---|
| Y/N | Yeast/ Bladder infections  | Y/N | Pelvic Pain                                 |
| Y/N | Painful intercourse  | Y/N | Low back pain                               |
| Y/N | Constipation   | Y/N | Arthritis/ Rheumatoid arthritis             |
| Y/N | Diabetes   | Y/N | Abdominal pain                              |
| Y/N | Neurological Muscle Disorders  | Y/N | Stroke                                      |
| Y/N | Asthma   | Y/N | Heart disease/ Pacemaker                    |
| Y/N | Allergies  | Y/N | Emphysema/ Bronchitis/ Lung disease         |
| Y/N | Smoking habit  | Y/N | Circulatory problems                        |
| Y/N | Sexually transmitted disease<br>or other communicable disease                | Y/N | Cancer, please specify _____                |
| Y/N | Depression   | Y/N | Gastrointestinal or irritable bowel disease |
| Y/N | Thyroid dysfunction  | Y/N | Trauma to the pelvis (i.e. fall)            |
| Y/N | Have you ever been diagnosed with or suspect that you have had a concussion? | Y/N | Other _____                                 |

Please explain and provide dates for any "yes" answers:

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

- Y/N Are you currently in menopause?  
Y/N Are you currently pregnant?  
Y/N Actively trying to conceive?  
Y/N Have you ever been pregnant? Please list number, date(s) and outcome below (ie: vaginal delivery, cesarean section, miscarriage, abortion):

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

If you had a vaginal delivery, did you have an episiotomy? Tearing?

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

Please list any past surgical procedures and date(s):

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

Please list any current medications you are taking (prescription and over the counter) and for what reason:

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

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What is your occupation? Do you work full time or part time? What physical activity is required in this position?

\_\_\_\_\_

Do you exercise? Please give description: \_\_\_\_\_

\_\_\_\_\_

### Urination History

1. Do you experience urinary leakage: never \_\_\_ 1/week \_\_\_ 2-3/week \_\_\_ 1/month \_\_\_ >1/day \_\_\_

	Always	Sometimes	Never
Do you have trouble making it to the toilet in time?			
Do you lose urine when you have a strong urge to urinate?			

Do you lose urine with any of the following:

	Always	Sometimes	Never
Coughing or Sneezing			
Laughing			
Active exercise (running, etc)			
Minimal exercise (walking, light housework)			
Sleeping			
Nervousness/increased anxiety			
Leakage unrelated to any specific cause			
Other (please specify below)			

2. Do you ever you leak urine without feeling it? Yes \_\_\_ No \_\_\_
3. Amount of urine leakage: None \_\_\_ small amount \_\_\_ moderate amount \_\_\_ large amount \_\_\_
4. Do you use any of the following: sanitary pads? \_\_\_ tissue paper? \_\_\_ diapers? \_\_\_
5. How many pads do you use per day? \_\_\_\_\_
6. How often do you urinate during the day? \_\_\_\_\_
7. How often do you urinate at night (during sleeping hours)? \_\_\_\_\_
8. Is the volume of urine you usually pass: large? \_\_\_ average? \_\_\_ small? \_\_\_ very small? \_\_\_
9. Do you experience any of the following urinary symptoms: incomplete emptying? \_\_\_ hesitancy? \_\_\_ slow stream? \_\_\_ intermittent stream? \_\_\_ difficulty initiating stream? \_\_\_\_\_
10. Do you experience pain with urination? Yes \_\_\_ No \_\_\_
11. Do you urinate frequently, before you experience the urge, just so you can stay dry? Yes \_\_\_ No \_\_\_
12. How many glasses of fluid do you drink per day? \_\_\_\_\_

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### **Bowel History**

13. Do you experience stool leakage: never \_\_\_ 1/week \_\_\_ 2-3/week \_\_\_ 1/month \_\_\_ >1/day \_\_\_

14. Do you experience gas leakage: never \_\_\_ 1/week \_\_\_ 2-3/week \_\_\_ 1/month \_\_\_ >1/day \_\_\_

15. What causes your stool or gas leakage?  
\_\_\_\_\_

16. Amount of stool leakage: None \_\_\_ small amount \_\_\_ moderate amount \_\_\_ large amount \_\_\_

17. How often do you have bowel movements during the week?  
\_\_\_\_\_

18. Do you experience pain with bowel movements? Yes \_\_\_ No \_\_\_

19. Do you have to use medication or suppositories to have a bowel movement? Yes \_\_\_ No \_\_\_

If Yes, what do you use and how often? \_\_\_\_\_  
\_\_\_\_\_

20. Do you splint or use your fingers to assist in having a bowel movement? Yes \_\_\_ No \_\_\_

21. Do you experience any other bowel or gas problems? Please explain:  
\_\_\_\_\_  
\_\_\_\_\_

### **Sexual History**

22. Are you currently sexually active? Yes \_\_\_ No \_\_\_

If "no", have you been sexually active in the past? Yes \_\_\_ No \_\_\_

If "yes", are you currently refraining from sexual activity because of the problem(s) that bring you to physical therapy? Yes \_\_\_ No \_\_\_

23. Does your sexual practice (past or present) include any anal entry activities? Yes \_\_\_ No \_\_\_

24. Do you experience/Have you experienced painful intercourse (Dyspareunia)? Yes \_\_\_ No \_\_\_ N/A \_\_\_

25. Do you experience/Have you experienced painful sexual activity? Yes \_\_\_ No \_\_\_ N/A \_\_\_

26. During a gynecological exam, do you experience pain with the speculum? Yes \_\_\_ No \_\_\_

27. Have you ever experienced physical, sexual, verbal or emotional abuse or trauma? Yes \_\_\_ No \_\_\_

If "yes", is the abuse occurring currently? Yes \_\_\_ No \_\_\_

Is this still a factor in your life physically, emotionally and/or psychologically? Yes \_\_\_ No \_\_\_

Is there anything else you would like to comment on or add to the information on this form?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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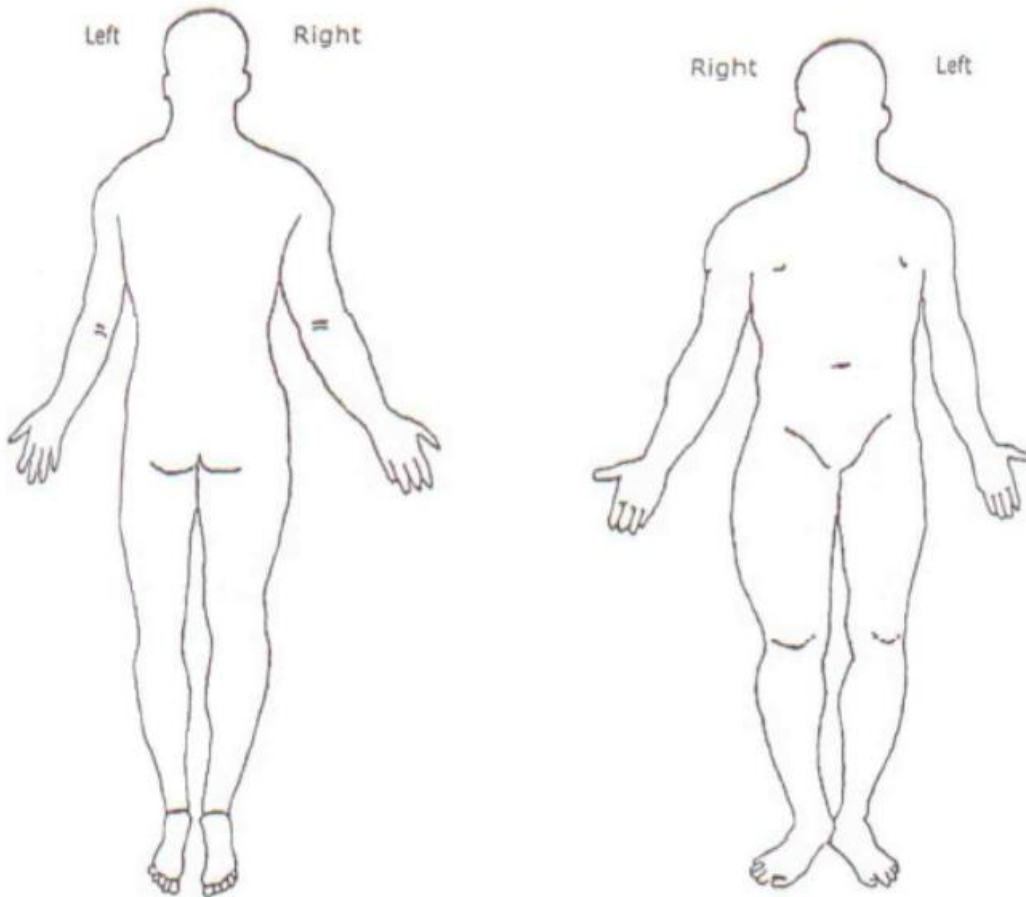
## Pain Scale

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Pain:** mark an **X** on the body part(s) where you have pain.

**Numbness:** mark an **O** on the body part(s) where you have numbness.



Typically, my pain level is:

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

At its worst, my pain level is:

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

At its best, my pain level is:

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

0 = no pain

5 = moderate pain

10 = severe pain

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### Patient Attendance Policy

Marathon Physical Therapy & Sports Medicine is committed to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of care. To achieve the best possible outcome, it is very important that you attend your therapy sessions, as scheduled.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, no-shows, and tardiness, decrease our ability to accommodate the scheduling needs of our patients.

### Cancellation Policy

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Marathon Physical Therapy & Sports Medicine requires at least 24 hours' notice for any cancelled appointments. This includes appointments that are cancelled and rescheduled for a different day.

Cancellations due to menstruation must also have 24-hour notice, as a menstruation does not contraindicate treatment, and internal treatment can be avoided during menstruation.

A \$50 cancellation fee will be assessed for cancellations without 24 hours' notice.

### No-Show Policy

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Patients who do not show up for their appointment without a call to cancel will be considered as No-Show. Patients who No-Show three (3) consecutive appointments will be dismissed from the practice, thus they will be denied any future appointments.

A \$50 No-Show fee will be assessed for all no shows.

### Lateness Policy

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It is equally important that you are on time for your scheduled appointment. If you are aware that you are going to be late, please call the office and let us know. We cannot guarantee that we will be able to treat you if you are more than 15 minutes late for an appointment. If we are unable to treat you due to tardiness, your appointment will be considered a No-Show.

Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. Having pain or not having pain are NOT reasons to cancel or no-show your scheduled treatment. If you are in pain, it is important to come in because there are treatments available and/or program modifications that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your care to progress your plan and prepare for discharge and provide self-management.

I consent to the above, as indicated by my signature below:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### Patient Authorization and Guarantee

#### Release of Information

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Marathon Physical Therapy and Sports Medicine, LLC to my physician(s), as well as any organization responsible for payment of my account, and any legal representative involved in my litigation. I also authorize the release of information by telephone or in writing for utilization and quality review purposes.

#### Assignment of Insurance Benefits

I hereby authorize that the payment of authorized benefits be made directly to Marathon Physical Therapy and Sports Medicine, LLC for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

#### Valuables

I hereby understand that Marathon Physical Therapy and Sports Medicine, LLC is not responsible for valuables and personal property brought to the facility.

#### Consent of Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of the treating clinician, may be considered necessary or advisable while I am a patient of Marathon Physical Therapy and Sports Medicine, LLC.

#### Guarantee of Account

In consideration of services rendered to me by Marathon Physical Therapy and Sports Medicine, LLC, I hereby guarantee payment for any and all services rendered to me in which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance and/or deductible which I am fully responsible for paying. Although Marathon Physical Therapy and Sports Medicine, LLC will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will immediately notify Marathon Physical Therapy and Sports Medicine, LLC of any changes in my insurance coverage while receiving physical therapy.

#### Medicare

I hereby certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

I, \_\_\_\_\_, by signing this document, acknowledge my consent to the above:  
(Print Name)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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### Acknowledgement of Receipt of Privacy Notice

#### Purpose of this Acknowledgement

This acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR § 164.520©(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

#### Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Marathon Physical Therapy and Sports Medicine, LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 250 East Main St., Norton, MA 02766, Attention: Practice Compliance Director.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): \_\_\_\_\_

I understand the foregoing provisions, and wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purpose of treatment, payment and healthcare operations.

By signing this form, I acknowledge that I have reviewed an executed copy of this acknowledgement and a copy of the Practice's Policy Notice and agree to the Practice's use and disclosure of my protected health information for treatment, payment and health care operations.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature of Patient/Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

(Office use only) The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

\_\_\_\_\_ Accepted

\_\_\_\_\_ Denied

\_\_\_\_\_ Not Applicable

\_\_\_\_\_ Other (explain) \_\_\_\_\_

\_\_\_\_\_ Initial