Chittenango Physical Therapy

Name:_____ Date of Birth:_____/_____/_____

SS Number:_____

Address:_____

City State Zip

Primary Phone Number:_____Secondary Phone Number:_____

E-Mail Address:_____

Appointment Reminders:

☐ Yes, please **call** my phone the day before to remind me Phone:_____

☐ Yes, please send me a **text** message the day before to remind me Phone:_____

Emergency Contact:_____ Contact Phone Number:_____

Referring Doctor:_____

Primary Insurance:_____Secondary Insurance:_____

(Please present your insurance card(s) to the receptionist - Thank you!)

Where did you hear about Chittenango Physical Therapy?

Family/Friend Print Ad Doctor Website Online Search Insurance Radio Other:_____

Designated Individuals Authorization (Optional)

List anyone you would like Chittenango Physical Therapy to be able to correspond with about your care.
(Example: Family Members, Parents, Siblings, Spouse, Lawyer, Caregiver etc.)

I hereby authorize one or all of the designated parties below to request and receive any of my protected health information regarding treatment, payment or administrative operations. I understand that the identity of these designated parties will be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____

Patient Signature

_____

Date

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

Your protected health information will be used by Chittenango Physical Therapy or disclosed to others only for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Prior to signing this form, you may review the full Notification of Privacy PRactices for a more detailed description of how your protected health information may be used or disclosed.

I have been notified of the Privacy Practices for Chittenango Physical Therapy.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

Signature of Patient
Representative:_____
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

Chittenango Physical Therapy

FAX: 315-510-3688
PHONE: 315-510-3372
1398 State Route 5
Chittenango, NY 13037

Pelvic Floor Examination Consent

A Thorough and complete examination of the pelvic floor region by a trained physical therapist may involve both internal and external assessment of the pelvic floor muscles and function. Patient comfort is a priority and a patient reserves the right to stop the examination or treatment at any time by verbally communicating to the treating therapist that they are no longer comfortable and would like to stop.

Patients reserve the right to have a spouse/partner or other family member present at the time of initial examination or during any treatment session if wanted. You may also request that another faculty member be present (PT aides will be available to assist during pelvic floor therapy treatments as needed).

CONSENT: I Consent to both internal and external examination of the pelvic floor region during physical therapy evaluation and subsequent treatment sessions.

Patient Signature:_____ Date:_____

Verbal consent will also be attained by the treating therapist prior to internal examination or assessment.

Medical History- Do you have any of these conditions? (Males)

NEUROLOGICAL
- ☐ Stroke
- ☐ Tia (Mini strokes)
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Dementia
- ☐ Seizures
- ☐ Peripheral neuropathy
- ☐ Pudendal neuralgia

MENTAL HEALTH
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Anxiety disorder
- ☐ PTSD
- ☐ Insomnia
- ☐ OCD
- ☐ Abuse/Trauma

VISION AND HEARING
- ☐ Hard of hearing

DERMATOLOGICAL
- ☐ Psoriasis
- ☐ Eczema

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart disease
- ☐ Congestive heart failure
- ☐ Angina
- ☐ Heart attack
- ☐ Cardiac/defibrillator
- ☐ Vascular disease

HEMATOLOGICAL/IMMUNE
- ☐ Anemia
- ☐ Sickle cell
- ☐ Vitamin deficiency
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Auto-immune

CANCER
- ☐ Type:_____
- ☐ Treatment:_____

RESPIRATORY
- ☐ COPD/emphysema
- ☐ Bronchitis
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Seasonal allergies

ENDOCRINE
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

DIGESTIVE
- ☐ Acid reflux/GERD
- ☐ Diverticulosis
- ☐ Constipation
- ☐ Chronic diarrhea
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease
- ☐ Celiac disease
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Hemorrhoids
- ☐ colostomy/Ileostomy

UROLOGICAL
- ☐ Overactive bladder
- ☐ Urinary incontinence
- ☐ Interstitial cystitis
- ☐ Bladder pain syndrome
- ☐ Bladder infections (UTI'S)
- ☐ Kidney disease
- ☐ Stones

MUSCULOSKELETAL
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Tailbone/pelvis trauma
  - ☐ Trauma from recent or past fall
  - ☐ Trauma from vehicle accident
- ☐ Diastasis Recti
- ☐ Sciatica
- ☐ Stenosis
- ☐ Scoliosis
- ☐ Herniated disc
- ☐ Degenerative discs
- ☐ Fracture:_____
- ☐ Sprain:_____
- ☐ Low back pain
- ☐ Hip pain

MALE=PROSTATE
- ☐ Enlarged Prostate
- ☐ Prostate infections
- ☐ Chronic Prostatitis
- ☐ Prostate Pain
- ☐ Achieving erection
- ☐ Maintaining erection
- ☐ Difficulty with ejaculation
- ☐ erectile/ejaculation pain
- ☐ infertility

Please list any medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any of these symptoms? (Male & Female)

GENERAL BODY SYMPTOMS
- ☐ Fever, chills, night sweats
- ☐ Weight changes
- ☐ Unexplained pain
- ☐ Excessively chronically tired
- ☐ Dizziness, fainting
- ☐ Trouble sleeping

SKIN, HAIR, AND NAILS
- ☐ Dry Skin, Itching, rash
- ☐ Irregularly shaped moles
- ☐ Unexpected bruising
- ☐ Unexpected hair loss
- ☐ Changes in nail appearance

NERVES AND MEMORY
- ☐ Headaches
- ☐ Tingling, numbness
- ☐ Forgetfulness, confusion
- ☐ Trouble concentrating

MOOD AND FEELINGS
- ☐ Anxiousness, nervousness
- ☐ Sadness, hopelessness
- ☐ Lost of interests/purpose
- ☐ Wanting to die

EYES AND VISION
- ☐ Drooping eyelids

EARS, NOSE, MOUTH, AND THROAT
- ☐ Swollen glands
- ☐ Dry mouth

HEART AND VESSELS
- ☐ Chest pain
- ☐ Racing heart
- ☐ Dizziness upon standing
- ☐ Swelling in feet or hands

LUNGS AND BREATHING
- ☐ Chest Pain
- ☐ Shortness of breath
- ☐ Frequent coughing/sneezing
- ☐ Bloody Phlegm

STOMACH AND DIGESTION
- ☐ Indigestion/heartburn
- ☐ Nausea, vomiting
- ☐ Change in appetite
- ☐ Stomach Pain, Cramping
- ☐ Bloating

BOWELS AND DEFECATION
- ☐ Constipated
- ☐ Diarrhea
- ☐ Fecal Leakage
- ☐ Incomplete emptying of bowels
- ☐ Feeling of rectal obstruction
- ☐ Changes in stool color/formation
- ☐ Effortful bowel movements
- ☐ Painful bowel movements
- ☐ Rectal or tailbone pain

BLADDER AND URINATION
- ☐ Urine leakage
- ☐ Strong, sudden urges to void
- ☐ Bladder or urethral pain
- ☐ Pressure, burning sensations
- ☐ Frequent toilet visits
- ☐ Incomplete bladder emptying
- ☐ Urine stream changes
- ☐ Weak urine stream

GENITALS
- ☐ Pain, itching or burning
- ☐ Redness or white patches
- ☐ Feeling of warmth
- ☐ Feeling of coldness
- ☐ Lumps or wounds
- ☐ Change in libido/sexual respose
- ☐ Genital pain with sitting
- ☐ Pain during or after sex

FEMALE REPRODUCTIVE
- ☐ Vaginal dryness
- ☐ Clitoris or vaginal pain
- ☐ Pelvic pressure or pain
- ☐ Falling out feeling
- ☐ Vaginal bulge
- ☐ Difficult pregnancy or labor

MALE REPRODUCTIVE
- ☐ Erectile issues
- ☐ Tip or shaft or penis pain
- ☐ Scrotal or testicle pain
- ☐ Perineal pain
- ☐ Prostate pain

SPEECH AND SWALLOWING
- ☐ Voice or speech changes
- ☐ Word finding difficulties

MUSCLE AND BONES
- ☐ Diffuse muscle aches
- ☐ Muscle tightness
- ☐ Muscle spasm
- ☐ Tremors
- ☐ Shaking
- ☐ Lake of coordination
- ☐ arm/leg weakness
- ☐ Hand or finger weakness
- ☐ Poor posture
- ☐ Joint stiffness
- ☐ Joint swelling

STABILITY AND BALANCE
- ☐ Falls-current or history of
- ☐ Near falls
- ☐ Fear of falling
- ☐ Stumbling legs give away
- ☐ Unsteadiness
- ☐ Tripping over feet/toes

DIFFICULTY WITH:
- ☐ Using toilet
- ☐ Sitting
- ☐ Getting out of bed
- ☐ Standing up
- ☐ Walking
- ☐ Using stairs
- ☐ Running or jumping
- ☐ Exercising for health
- ☐ Taking care of a loved one
- ☐ Work/school performance
- ☐ Driving a vehicle

Are you currently exercising?

If so, what type:_____

How often:_____

Where are you exercising?

_____

Intensity:
- ☐ High
- ☐ Medium
- ☐ Low

Height:_____ Weight:_____

Other Symptoms:

_____

_____

_____

Bowel Function: Do you have a gastroenterologist? ☐ YES ☐ NO If yes, who?_____

Bowel Movement (BM) Frequency	**Bowel Movement Urge Delay Ability**	**Bowel movement Urge Intensity**
How often do you have a bowel movement? ☐ Less than once a month ☐ A few times a month ☐ Every 6-7 days ☐ Every 4-5 days ☐ Every 2-3 days ☐ Once a day ☐ 2-3 times a day ☐ 3-4 times a day ☐ 4-5 times a day ☐ 5-6 times a day ☐ 7 or more times a day ☐ I don't go for several days, then go multiple times in a day	How Long can you typically delay an urge to have a bowel movement? ☐ More than 5 hours ☐ 4-5 hours ☐ 3-4 hours ☐ 2-3 hours ☐ 1-2 hours ☐ 30-60 min ☐ 20-30 min ☐ 10-20 min ☐ 5-10 mint ☐ A few minutes ☐ I go as soon as I feel an urge	How would you rate the intensity of your urges to urinate? ☐ **Absent**- I don't feel urges to void at all. ☐ **Low**-I don't feel strong urges and I might have to remind myself to use the toilet. ☐ **Normal**- urges are controllable and I can urinate when it is convenient. ☐ **High**- I often feel strong urges that make me stop when I'm doing and rush to the toilet. ☐ **Leakage**- I feel strong urges and leak urine before I make it to the toilet.

Stool Consistency	**Gas Control**	**Fecal Leakage Frequency**
How would you describe your stool formation? Check all that apply. ☐ Watery Diarrhea ☐ Loose and unformed ☐ Loose but formed ☐ Soft and formed ☐ Hard and formed ☐ Hard, rocky, pellet-like	How well are you able to control gas or flatulence during a social situation? ☐ Never ☐ Rarely ☐ Occasionally ☐ Sometimes ☐ Often ☐ Always	How often do you accidentally leak or lose fecal matter? ☐ Never ☐ 1 time or less per month ☐ A few times a month ☐ A few times a week ☐ One or two times a day ☐ A few times a day ☐ Several times a day

Fecal Leakage Severity	**Protective Padding**	**Quantity padding is changed**
How much fecal matter do you lose during an accident? ☐ N/A ☐ Staining or soiling ☐ Very small amount ☐ Small amount ☐ Medium amount ☐ Large amount ☐ Entire bowel contents	What type of protective padding do you use for bowel control? ☐ N/A- none needed ☐ Change underwear ☐ Folded tissue paper ☐ Panty liner ☐ Thin pad ☐ Thick pad ☐ Diaper ☐ Vinyl or plastic underpants	How often do you change your protection? ☐ N/A-none needed ☐ Only when I leave the house ☐ Only during a cold or when I exercise ☐ 1 per day ☐ 2 per day ☐ 3 per day ☐ 4 per day ☐ 5 or more times per day

Fecal Incontinence Precipitating Factors

If you experience accidental or unplanned losses of fecal matter or of flatulence, when does it occur? Please check all that apply.

☐ Coughing, sneezing, laughing	☐ Approaching the toilet with an urge to urinate
☐ Getting out of bed, chair, or car	☐ Pulling down pants to use toilet
☐ Bending reaching, kneeling or squatting	☐ Around running water
☐ Standing or walking around for awhile	☐ Feeling cold, nervous, or anxious
☐ Running, jumping, or other strong exertions	☐ Entering the house
☐ During sexual activity	☐ Waiting too long/rushing to the toilet

International Prostate Symptom Score (I-PSS)

Patient Name: _____ **Date of birth:** _____ **Date completed** _____

In the past month:	Not at All	Less than 1 in 5 Times	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always	Your score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times**	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PSS Score							

Score: 1-7: *Mild* 8-19: *Moderate* 20-35: *Severe*

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

Initial number

ICIQ-UI Short Form

CONFIDENTIAL

DAY MONTH YEAR

Today's date

Many people leak urine some of the time. We are trying to find out how many people leak urine, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

1 Please write in your date of birth:

DAY MONTH YEAR

2 Are you *(tick one)*: Female ☐ Male ☐

3 How often do you leak urine? *(Tick one box)*

never ☐	0
about once a week or less often ☐	1
two or three times a week ☐	2
about once a day ☐	3
several times a day ☐	4
all the time ☐	5

4 We would like to know how much urine <u>you think</u> leaks.
How much urine do you <u>usually</u> leak (whether you wear protection or not)?
(Tick one box)

none ☐	0
a small amount ☐	2
a moderate amount ☐	4
a large amount ☐	6

5 Overall, how much does leaking urine interfere with your everyday life?
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

ICIQ score: sum scores 3+4+5 ☐☐

6 When does urine leak? *(Please tick all that apply to you)*

never – urine does not leak	☐
leaks before you can get to the toilet	☐
leaks when you cough or sneeze	☐
leaks when you are asleep	☐
leaks when you are physically active/exercising	☐
leaks when you have finished urinating and are dressed	☐
leaks for no obvious reason	☐
leaks all the time	☐

Thank you very much for answering these questions.

NIH Chronic Prostatitis Symptom Index (NIH-CPSI)

NAME: _____ DATE: _____ DOB: _____

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

		Yes	No
a.	Area between rectum and testicles (perineum)	☐ 1	☐ 0
b.	Testicles	☐ 1	☐ 0
c.	Tip of the penis (not related to urination)	☐ 1	☐ 0
d.	Below your waist, in your pubic or bladder area	☐ 1	☐ 0

2. In the last week have you experienced:

		Yes	No
a.	Pain or burning during urination?	☐ 1	☐ 0
b.	Pain or discomfort during or after sexual climax (ejaculation)?	☐ 1	☐ 0

3. How often have you had pain or discomfort in any of these areas over the last week?

- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Sometimes
- ☐ 3 Often
- ☐ 4 Usually
- ☐ 5 Always

4. Which number be describes you AVERAGE pain or discomfort on the days that you had it, over the last week?

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

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had the sensation of not emptying your bladder completely after you finished urinating, over the last week

- ☐ 0 Not at all
- ☐ 1 Less than 1 time in 5
- ☐ 2 Less than half the time
- ☐ 3 About half the time
- ☐ 4 More than half the time
- ☐ 5 Almost always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- ☐ 0 Not at all
- ☐ 1 Less than 1 time in 5
- ☐ 2 Less than half the time
- ☐ 3 About half the time
- ☐ 4 More than half the time
- ☐ 5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kind of things you would usually do, over the last week?

- ☐ 0 None
- ☐ 1 Only a little
- ☐ 2 Some
- ☐ 3 A lot

8. How much did you think about your symptoms, over the last week?

- ☐ 0 None
- ☐ 1 Only a little
- ☐ 2 Some
- ☐ 3 A lot

Quality of Life

9. If you were to spend the rest of your life with symptoms just the way they have been during the last week, how would you feel about that?

- ☐ 0 Delighted
- ☐ 1 Pleased
- ☐ 2 Mostly satisfied
- ☐ 3 Mixed
- ☐ 4 Mostly dissatisfied
- ☐ 5 Unhappy
- ☐ 6 Terrible

Scoring the NIH Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 3, and 4 = _____

Urinary Symptoms: Total of Items 5 and 6 = _____

Quality of Life Impact: Total of Items 7, 8, and 9 = _____