C.O.R.E.
PHYSICAL THERAPY CENTERS

Dear Women's Health Patient,

Welcome to C.O.R.E. Physical Therapy Center. Thank you for scheduling an appointment for women's health physical therapy. My mission is to provide specialized physical therapy evaluation and treatment in an effective and compassionate manner.

There are three forms for you to fill out prior to your first physical therapy appointment. Please bring the completed forms with you on your first visit. In addition, a physician's prescription/referral is required for women's health physical therapy; therefore I do require that you obtain this prior to our first visit from your ob/gyn or urologist. Please make sure they include your diagnosis and any results of tests or lab work.

1. General Intake Form
2. Women's Health Intake
3. Daily Voiding Log
4. A physician prescription/referral to physical therapy with a established diagnosis

Your first visit to the clinic will take approximately 45 minutes. I look forward to assisting and working with you. Please do not hesitate to contact me via phone or email with questions.

Sincerely,

Elizabeth Canoni PT, MS, DPT
drcanoni@coreptcenters.com

WELCOME TO OUR CLINIC

Registration Form

I chose clinic because/referred by: ❑ Dr._____ ❑Insurance Company ❑Hospital
❑Family ❑Friend ❑Close to home ❑Close to work ❑Yellow Pages ❑ Advertisement

PATIENT INFORMATION

Patient Name: _____Birth Date ___/____/____
Address: _____Age: ____
Social Security Number _____-_____-_____ Sex: ❑Male ❑Female
Marital Status: Single Married Widowed Separated Divorced In a committed relationship
Are you employed? ❑ yes❑ no ❑retired Are you disabled? ❑yes ❑no Reason:_____
Occupation(former occupation if retired):_____
Employer:_____Employer Address:_____

CONTACT INFORMATION

Please include only numbers we may call.
Home #:_____ Work #: _____ EXT. _____
Cell #:_____ Email*:_____
*If you supply us with an email you will automatically receive our clinic newsletter. You may opt out now or later if you wish.
My preferred method to reach me during the day is:home /cell /work /email

In case of emergency, contact:

Name: _____ Relationship:_____
Home #: _____ Work#:_____ Cell#_____
Primary Care Doctors Name:_____Phone #:_____

CANCELLATION/NO SHOW POLICY

If you need cancel an appointment and give more that 24 hours notice, you will not be charged. If you cancel or no show less than 24 hours in advance, you will be charged a cancellation fee of $25.00.

ASSIGNMENT OF BENEFITS

❑I authorize the C.O.R.E. Physical Therapy Centers to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
❑I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.
❑I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me. I understand that I am responsible to pay co pays or deductibles.
❑I authorize payment of health benefits otherwise payable to me, directly to C.O.R.E. Physical Therapy Centers.
❑I permit a copy of this authorization to be used in place of the original.
❑This "Signature on File" is valid for one year from the date indicated below.

Signature of Beneficiary or Guardian Medicare # (if applicable) Date

Health Insurance

Do you have health insurance? ❑yes ❑no If yes please fill out below:
Insurance Name:_____
Name of Insured: _____ Relationship to insured:_____
Patient ID#:_____ Group#(if any): _____

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Women's Health Intake

Name _____ **Age**_____ **Date**_____

1. Describe the current problem that brought you here?_____
_____

2. When did your problem first begin?___months ago or ___ years ago.

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____
_____

4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how?_____

5. If pain is present rate pain on a 0-10 scale 10 being the worst._____ Describe the nature of
the pain (i.e. constant burning, intermittent ache)_____
_____

6. Describe previous treatment/exercises_____
_____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than_____ minutes
___ Walking greater than _minutes
___ Standing greater than _ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list _____

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers -running water/key in door
___ With nervousness/anxiety
___ No activity affects the problem

8. What relieves your symptoms?_____
_____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst __

Pg 2 History **Name**_____

11. What are your treatment goals/concerns?_____

_____

Since the onset of your current symptoms have you had:

Y/N Fever/Chills
Y/N Malaise (Unexplained tiredness)
Y/N Unexplained weight change
Y/N Unexplained muscle weakness

Y/N Dizziness or fainting
Y/N Night pain/sweats
Y/N Change in bowel or bladder functions
Y/N Numbness / Tingling
Y/N Other /describe_____

_____

Health History: Date of Last Physical Exam _____ Tests performed_____

_____

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
Mental Health: Current level of stress High__ Med__ Low__ Current psych therapy? Y/N
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____

Have you ever had any of the following conditions or diagnoses? circle all that apply /describe

Cancer
Stroke
Emphysema/chronic bronchitis
Heart problems
Epilepsy/seizures
Asthma
High Blood Pressure
Multiple sclerosis
Allergies-list below
Ankle swelling
Head Injury
Latex sensitivity
Anemia
Osteoporosis
Hypothyroid/ Hyperthyroid
Low back pain
Chronic Fatigue Syndrome
Headaches
Sacroiliac/Tailbone pain
Fibromyalgia
Diabetes
Alcoholism/Drug problem
Arthritic conditions
Kidney disease
Childhood bladder problems
Stress fracture
Irritable Bowel Syndrome
Depression
Rheumatoid Arthritis
Hepatitis HIV/AIDS
Anorexia/bulimia
Joint Replacement
Sexually transmitted disease
Smoking history
Bone Fracture
Physical or Sexual abuse
Vision/eye problems
Sports Injuries
Raynaud's (cold hands and feet)
Hearing loss/problems
TMJ/ neck pain
Pelvic pain
Other/Describe_____

Surgical /Procedure History

Y/N Surgery for your back/spine
Y/N Surgery for your bladder/prostate
Y/N Surgery for your brain
Y/N Surgery for your bones/joints
Y/N Surgery for your female organs
Y/N Surgery for your abdominal organs
Other/describe_____

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #___
Y/N Vaginal dryness

Y/N Episiotomy #_
Y/N C-Section #__
Y/N Difficult childbirth #_
Y/N Prolapse or organ falling out
Y/N Other /describe_____

Y/N Painful periods
Y/N Menopause - when? _____
Y/N Painful vaginal penetration
Y/N Pelvic pain

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Other /describe_____

Y/N Erectile dysfunction
Y/N Painful ejaculation

Medications - pills, injection, patch Start date Reason for taking

_____
_____
_____
_____

Over the counter -vitamins etc Start date Reason for taking

_____
_____
_____
_____
_____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Other/describe _____

Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? _____minutes, ____hours, _____not at all
3. The usual amount of urine passed is: ___small ___ medium___ large.

4. Frequency of bowel movements ____ times per day, _____times per week, or _____.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____minutes, ___hours, _____not at all.
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
   Of this total how many glasses are caffeinated?__ glasses per day.
8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your period)
___With standing for _____ minutes or _____hours.
___With exertion or straining
___Other

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

11. What form of protection do you wear? (Please complete only one)
___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
___Other _____
On average, how many pad/protection changes are required in 24 hours? _____# of pads

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KEEPING A RECORD OF BLADDER FUNCTION

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. **Please complete a bladder log every day for 3 days and bring it with you to your appointment.**

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): Three methods

Record the time of day and 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 an 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 an 8 ounce measuring 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 seconds by counting "one - one thousand" (this equals one second) while emptying your bladder. Record the total number of seconds it took you to void.
3. Measure urine amounts with a collection device. The best method is a collection "hat" that can be placed directly over the toilet. Ask your provider where to get one. Some people use 2-4 cup measuring containers, but it is sometimes difficult to catch the urine with these. Record the measured ounces of urine in the box at the corresponding time interval each time you urinate.

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 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 a 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.

Daily Voiding Log Sample

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided in Ounces or 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 6:45 am	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		S		1	Key in the door
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:____

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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**

C.O.R.E.
PHYSICAL THERAPY CENTERS

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**