DES MOINES UNIVERSITY CLINIC

Welcome to our practice;

In the DMU Physical Therapy Clinic we emphasize the latest research, self-reliance and effective, yet gentle, hands-on treatment.

All sessions of a sensitive nature are carried out in our private, comfortable treatment rooms. Expect your first visit to last about an hour. We will spend as much time as necessary discussing your history and conditions and help you understand your symptoms and the anatomy involved. That same day we will most likely assess your posture, muscle strength and flexibility and low back/pelvis mobility.

Depending on your diagnosis, we may or may not elect to perform an internal vaginal or rectal exam to determine the condition of your pelvic floor muscles. Your pelvic floor muscles are just like any other muscle in your body, except they are located inside your pelvis and are hard to reach externally. These muscles can be tight, sore, long or weak, and are best reached internally for treatment. Treatment may consist of soft tissue massage, trigger point treatment, stretching, strengthening or muscle retraining (some people hold their pelvic floor muscles in a tightly contracted state and don't know it). A chaperone is available on request.

If your primary complaint is urine leakage, we will discuss helpful behavioral changes, such as diet and urge suppression techniques. You will be asked to fill out a bladder diary, consisting of how frequently you urinate, the beverages you drink and details about your urinary leakage, such as how often, how much and what activity you were doing when you leaked. This information can help you physical therapist decide on a bladder-retraining schedule to help you regain control over your bladder.

Des Moines University Physical Therapy Clinic is also a teaching clinic. A student may participate in your physical therapy care.

Please fill out the enclosed forms and bring them with you on your first visit.

Kari Smith DPT

Sincere regards,

Kari Smith, DPT, BCB-PMD

3200 Grand Avenue
Des Moines, Iowa 50312-4198

515.271.1700
FAX 515.271.1670
www.dmu.edu

MEDICAL HISTORY QUESTIONNAIRE-FEMALE

Name: _____ Primary Care Physician: _____

Date of Appointment: _____ Referring Physician: _____

Birth Date: _____ Next Physician Appointment: _____

Describe the reason for your appointment (your main complaint/problem):

_____

_____

What goals do you hope to accomplish with therapy?

_____

_____

When did the problem begin? _____Is it getting better? □ Worse? □ Stay the same? □

Have you ever been treated for this problem? _____ If yes, how?

_____

List activities or things that you cannot do because of this problem. (How does the problem affect your life)

_____

What are you currently doing to manage the problem:

_____

PAST MEDICAL HISTORY: (Please mark if Yes)

	Childhood Illness		High Blood Pressure		Cancer
	Heart Problems		Chronic Cough		Emotional Problems
	Lung Disease		Diabetes		Psychiatric Disorder
	Kidney Disease		Bowel Problems		Arthritis
	Kidney Infections		Seizure Disorder/Epilepsy		Serious Injury, Accident
	Urinary Tract		Stroke		Glaucoma
	Liver Disease		Neurologic Disease		Thyroid Problems
	Back Problems		TB		Other

SURGICAL HISTORY: Have you ever had any operations? Yes □ No □ (If yes, please list)

_____

_____

_____

MEDICATIONS: Please list all your present medications, including doses:

_____ _____
_____ _____
_____ _____
_____ _____

Do you have any allergies to medicines? Yes □ No □ Please list any allergies and reactions:

_____ _____
_____ _____
_____ _____

PLEASE FILL IN THE FOLLOWING INFORMATION:

Number of pregnancies: ____
Vaginal deliveries: _____ Forceps/Vacuum_____ Episiotomy/tears_____
Cesarean deliveries: _____ Why? _____
Problems during delivery: _____
Did you experience incontinence during pregnancy? _____
Age with first_____ and last_____ deliveries
Are your periods: regular? _____ abnormally painful? _____
If painful, how do you cope? _____
Have you gone through menopause? _____ If yes, at what age? _____
Reason for menopause: natural □ hysterectomy □
Have you had any gynecologic problems? _____
Do you have a history of yeast infections? _____
Have you had any venereal diseases? Yes □ No □ If yes, which _____

SOCIAL HISTORY:

Current Marital Status: S □ M □ W □ D □
Are you sexually active? Yes □ No □
Occupation: _____
Retired? Yes □ No □

Have you ever smoked tobacco? Yes □ No □
If so, how much? _____
Have you quit? Yes □ No □
Do you drink alcohol? Yes □ No □
If so, how much? _____
Do you use any street drugs? Yes □ No □
If so, what? _____

HEALTH HABITS: (Please answer in space provided)

Do you see a doctor regularly for exams? _____
How many hours do you sleep at night? _____
Do you eat a well-rounded diet? _____
Do you exercise regularly? _____ If yes what type? _____
Do you consider yourself to be healthy? _____
Do you have any physical limitations? _____

FEMALE VOIDING QUESTIONNAIRE YES NO

Have you been treated for more than two urinary tract infections this year? □ □

When was the last time you had a urinary tract infection? _____

Is your urine ever bloody? □ □

Have you ever been treated with urethral dilation? □ □

If so, how many times? _____ Did it help?

CHILDHOOD BLADDER HABITS

Did you have difficulty holding urine as a child? □ □

As a child did you wet the bed beyond age 5? □ □

URGENCY/FREQUENCY

Do you feel that you urinate too often? □ □

Do you usually get up to urinate during the sleeping hours? □ □

If yes, how many times? _____

How many times during the day do you urinate?

1-4 □ 5-8 □ 9-12 □ more than 12 □

How often do you pass urine during the day? Every _____ hours

Is the volume of urine you usually pass?

Very small □ small □ average □ large □

Do you restrict your fluid intake because of your bladder problem? □ □

Do you constantly feel an urge to urinate? □ □

Do you often experience a strong, sudden urge to urinate? □ □

Do you often feel you must rush to reach the toilet? □ □

If yes, does it occur: all/most of the time □ half the time □ some of the time □

How long can you hold back the urge to urinate? _____

Do you lose urine when you have the urge to urinate? □ □

Do you experience a strong sense of urgency with any of the following:

Temperature changes □ □

Running water □ □

Entering the house □ □

Approaching the toilet □ □

Other: _____ □ □

Do you sometimes feel you need to urinate again immediately after urinating? □ □

Do you void before leaving the house "just in case"? □ □

Are you conscious of where the nearest toilet is when you are away from home? □ □

VOIDING SYMPTOMS

Do you have difficulty emptying your bladder completely? □ □

If yes, does it occur: all/most of the time □ half of the time □ some of the time □

How do you manage this problem? _____

Is the urine stream ever hesitant or interrupted? □ □

If yes, does it occur: all/most of the time □ half of the time □ some of the time □

Do you need to strain to empty? □ □

If yes, does it occur: all/most of the time □ half of the time □ some of the time □

Do you have difficulty telling when your bladder is full? □ □

Do you dribble just after urinating (i.e when you stand up)? □ □

If yes, does it occur: all/most of the time □ half of the time □ some of the time □

Do you have trouble stopping your urine midstream? □ □

URINARY INCONTINENCE:

		YES	NO
Do you experience uncontrollable loss of urine?		□	□
Do you lose urine with:	Coughing	□	□
	Sneezing	□	□
	Lifting objects	□	□
	Straining	□	□
	Bending	□	□
	Walking	□	□
	During intercourse	□	□
	After intercourse	□	□

Is the volume you lose:
□ a few drops □ wet underwear or pad □ soaked pad or clothing

Do you lose urine with a strong urge that cannot be controlled? □ □
If yes, does it occur: all/most of the time □ half of the time □ some of the time □
Is the volume you lose:
□ a few drops □ wet underwear □ soaked pad or clothing

In which positions does urine loss usually occur?

Lying down	□	□
Sitting	□	□
Standing	□	□
Moving from sitting to standing position	□	□

Is your loss of urine a continual drip so that you feel constantly wet? □ □
Do you ever lose urine without any warning or urge? □ □
If yes, please explain when/how? _____
Do you lose urine without feeling it happen? □ □
Do you lose urine while you sleep? □ □
Do you wear protection for urine loss? □ □
What type? _____ how many per day? _____
Do you experience hygiene or skin problems related to your leakage? □ □

BLADDER PAIN:
Do you have discomfort associated with your bladder? □ □
(if no, to above question, go directly to bowel section below)
If yes, location/description of pain _____
Indicate events that cause pain and rate the severity on a scale of 0 to 10 (0-none, 10- worst pain ever)

With bladder fullness □	pain rating _____/10
During voiding □	pain rating _____/10
After voiding □	pain rating _____/10
Other _____	pain rating _____/10

What activities are limited by your pain? _____
What makes the pain worse? _____
What makes the pain better? _____
How long have you had any of the bladder problems indicated in the sections above? _____
List any event that was associated with the onset of your bladder problem (such as accident, surgery, childbirth) _____
_____

BOWEL HABITS YES NO

How often do you have a bowel movement? _____

Do you ever attempt evacuation without results? □ □

If yes, how often: _____

Do you use any of the following to help you evacuate?

Laxatives (type _____) □

Suppository □

Enema □

Manual Removal □

Fiber supplement □

TYPICAL STOOL CONSISTENCY:

Separate hard lumps, like nuts □

Sausage shaped but lumpy □

Like a sausage or snake but with cracks on the surface □

Like a sausage or snake but smooth and soft □

Soft blobs with clear cut edges □

Fluffy pieces with ragged edges or mushy stool □

Watery, no solid pieces □

Combination of above □

Do you ever experience blood in the stool or on the tissue? □ □

Do you experience a sensation of the need to evacuate? □ □

If yes, rate this sensation: normal □ blunted/uncertain □ strong/urgent □

Do you constantly feel an urge to evacuate? □ □

Do you lose stool with a strong urge that cannot be controlled? □ □

If yes, does it occur: all/most of the time □ half the time □ some of the time □

How long can you hold the urge to evacuate? _____

Do you have a problem with constipation? □ □

Do you strain to pass stool? □ □

If yes, does it occur: all/most of the time □ half the time □ some of the time □

On average, how much time do you spend on the toilet for each evacuation? _____

Do you have difficulty emptying your bowels completely? □ □

If yes, does it occur: all/most of the time □ half of the time □ some of the time □

Do you feel stool remains: at the anal opening □ higher in the rectum/colon □

Do you have difficulty with hygiene after a bowel movement ? □ □

Are you unable to feel the difference between solid or liquid stool and gas? □ □

BOWEL INCONTINENCE YES NO

Are you unable to avoid passing gas in public? □ □
Do you experience uncontrollable loss of stool or stool seepage? □ □
(if you answered no to above question, go directly to bowel/abdominal pain section)

Do you lose stool with:			
	Cough /sneeze	□	□
	Aerobic Exercise	□	□
	Lifting/straining	□	□
	Releasing gas	□	□
	Urinating	□	□
	Intercourse	□	□

Is the amount you lose?
□ Stain/smear □ 2 Tbsp. or less □ ¼ to ½ cup □ ½ to 1 cup □ greater than 1 cup
If yes to above, consistency of stool loss: formed/solid□ hard balls□ loose/unformed□ liquid/mucous□
How often does this happen? _____

Do you ever lose stool without any warning or urge? □ □
If yes, please explain when/how _____
Do you lose stool without feeling it happen? □ □
If yes, please explain when and how? _____

Does the stool loss, seepage or staining occur after bowel movement? □ □
Does the stool loss, seepage or staining during sleep? □ □

Do you wear protection for stool loss? □ □
What type? _____ how many per day? _____

BOWEL/ABDOMINAL PAIN
Do you experience pain related to bowel function? □ □
(If no, to above question, go directly to pelvic pain section)
If yes, location/description of pain_____

Indicate events that cause pain and rate the severity on a scale of 0-10 (0-none, 10-worst pain ever)
Before bowel movement □ pain rating_____/10
During bowel movement □ pain rating_____/10
After bowel movement □ pain rating_____/10
With meals □ pain rating_____/10
Other: _____ pain rating_____/10

What activities are limited by your pain? _____
What makes pain worse? _____
What makes the pain better? _____
How long have you had the bowel pain indicated in the sections above? _____
List any event that was associated with the onset of your bowel problem (such as accident, surgery, childbirth)_____

PELVIC PAIN YES NO

Do you experience pelvic pain? □ □
(if no, to above question, go directly to emotional factors)
If yes, give a description and location of the pain _____

Do you experience pain with intercourse? □ □
If yes, indicate which of the following cause ofpain and indicate the severity on a scale of 0 to 10 (0-none 10-worst pain ever)
Initial penetration □ pain rating_____/10
Thrusting □ pain rating_____/10
Orgasm □ pain rating_____/10

Does the pain continue after intercourse? □ □
If yes, indicate: pain rating_____/10
How long does the pain last? _____hours/days
Indicate other events that cause pain and rate the severity on a scale of 0 to 10 (0-none, 10-worst pain ever)
During pelvic exam □ pain rating_____/10
Insertion of tampon □ pain rating_____/10
Sitting □ pain rating_____/10
Certain clothing □ pain rating_____/10
Other (describe)_____pain rating_____/10

What activities are limited by your pain? _____
What makes pain worse? _____
What makes the pain better? _____
How long have you had the pelvic pain indicated in the sections above? _____
List any event that was associated with the onset of your pain symptoms (such as accident, surgery, childbirth)_____

EMOTIONAL FACTORS:

Does emotional stress affect symptoms of your:	Bladder	□	□
	Bowel	□	□
	Pelvic pain	□	□
Have you ever experienced	Domestic violence	□	□
	Rape	□	□
	Sexual abuse/molestation	□	□
	Date Rape	□	□
	Incest	□	□
Have you ever been diagnosed with and/or treated for a nervous condition?		□	□
Have you ever been diagnosed with and/or treated for depression?		□	□

SYMPTOM SEVERITY:
Rate your feeling as to the current severity of your bowel, bladder, or pelvic floor problem on a scale of 1-10 with 10 being most severe.
0 1 2 3 4 5 6 7 8 9 10

Rate the following statement as it applies to you today, with 0 not true at all, 10 being true:
My problem is controlling my life.
0 1 2 3 4 5 6 7 8 9 10

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
First Name Used:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Legal Sex: Assigned Sex at Birth:
Gender Identity: Male____ Female____
Transgender Male____ Transgender Female____
Gender Non-conforming____ Self Identify _____
Sexual Orientation: Heterosexual____ Homosexual____ Bisexual____
Other____ Do Not Know____ Choose Not To Disclose____
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language: Race:
Ethnicity: **Relationship Status:**

Guarantor Information (to whom statements are sent)

Name:
Address:
Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone: **Mobile Phone:**

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by:
Primary Care Provider:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:
Crossroads:
Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Gender on Insurance (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Gender on Insurance (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

ACKNOWLEDGEMENT AND AUTHORIZATION:

- Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more full described in Des Moines University's Notice of Privacy Practices (NPP). Des Moines University is permitted to revise its NPP at any time. We will provide you with a copy of the revised NPP upon your request.

By signing below, you are acknowledging that you have received a copy of Des Moines University's Notice of Privacy Practices

Signed_____ **Date:**_____

- I understand that I am financially responsible to pay Des Moines University it's usual charges for all services received through Des Moines University, including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Des Moines University, and direct that payment of proceeds be made directly to Des Moines University.

- I authorize the release of medical record information or excerpts thereof to any insurance company or third party payor for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization, per HIPAA regulations.

- I authorize Des Moines University Clinic to obtain/have access to my medication history.

- I authorize the healthcare providers of DMU Clinic to administer treatment as deemed necessary for my care. As a teaching institution, students may be involved in my care. I certify that no guarantee has been made as to the results that may be obtained from the treatment. This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Signed_____ **Date:**_____

Medicare Secondary Payer Questionnaire: To be completed by patients who present with Medicare insurance products.

1. Do you have any group health insurance coverage based upon your current or former employment? Yes ____ No ____

2. Do you have any group health insurance coverage based upon your spouse or other family member's current employment? Yes ____ No ____

3. Are you receiving any of the following benefits?

Black Lung	Yes ____	No ____
Veterans Administration	Yes ____	No ____
End Stage Renal Disease	Yes ____	No ____

4. Is this service related to an automobile injury or illness? Yes ____ No ____
Is this service related to a work-related injury or illness? Yes ____ No ____
Is this service related to any other third party liability injury or illness? Yes ____ No ____

If you have answered yes to any of the above questions, we will request further benefit information.

Des Moines University Clinic
3200 Grand Ave
Des Moines, IA 50312

COMMUNICATION FORM

I give permission for DMU clinic employees to contact me and leave messages in the manner listed below as it relates to my care at Des Moines University Clinic.

CONTACT INFORMATION:

Home Phone #:	May clinic staff leave a message at this number? □ Yes □ No
Work Phone #:	May clinic staff leave a message at this number? □ Yes □ No
Mobile Phone #:	May clinic staff leave a message at this number? □ Yes □ No

Please indicate your primary contact preference: □ Home # □ Work # □ Mobile # □ Mail □ Portal

Email address:_____

AUTOMATED MESSAGING PREFERENCES: Please indicate how you would like to receive automated messages. You can choose more than one option; for example, you can get appointment reminders via Email, phone, and text messaging. If you do not check an option in a category below, you have "Opted Out" of receiving messages for that category: example if you do not check an option under Announcements you will not receive any announcements.

Health Notifications:	□ Email □ Phone* □ Text Message*
Appointment:	□ Email □ Phone* □ Text Message*
Announcements:	□ Email □ Phone* □ Text Message*
Billing:	□ Email □ Phone* □ Text Message*

*If you checked any "text message" box above, you are giving DMU permission to send a text to your mobile number.
*If you checked any "phone" box above and we have your mobile number listed, you are giving DMU permission to call your mobile number.

To change any of your communication preferences, including enrolling in text message appointment reminders, log in to your "My DMU Chart" portal account and indicate your Contact Preferences under the My Profile tab.

I have designated the people listed below as being involved in my health care. They may also be privy to any related financial or insurance information at DMU Clinic. I give DMU permission to disclose this information with these designated people.

Name	Phone Number	Relationship	May a message be left at this number?
			□ Yes □ No
			□ Yes □ No

The people listed below **MAY NOT** have access to my health care and financial / insurance information at DMU. For termination of parental rights, we must have the supporting legal documentation on file. If we do not have the supporting legal documentation on file, both parent will have access to medical / financial / insurance information.

Name	Relationship (e.g. parent, guardian)

_____ _____

Patient or legal representative signature **Date**