



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 your physical therapist decide on a bladder-retraining schedule to help you regain control over your bladder.

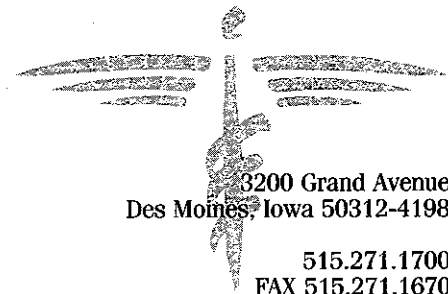
Des Moines University Physical Therapy Clinic is also a teaching clinic. A student may participate in your physical therapy care.

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

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

_____	_____
_____	_____
_____	_____
_____	_____

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

_____	_____
_____	_____
_____	_____
_____	_____

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 of exercise? _____
Do you consider yourself to be healthy? _____
Do you have any physical limitations? _____

MALE VOIDING QUESTIONNAIRE:**YES** **NO**

- Have you been treated for more than two urinary tract infection this year?
- When was the last time you had a urinary tract infections? _____
- 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 of 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?
- If yes, does it occur: all/most of the time half the time some of the time
- Do you experience a strong sense of urgency with any of the following?
- | | | |
|------------------------|--------------------------|--------------------------|
| Temperature change | <input type="checkbox"/> | <input type="checkbox"/> |
| Running water | <input type="checkbox"/> | <input type="checkbox"/> |
| Entering the house | <input type="checkbox"/> | <input type="checkbox"/> |
| Approaching the toilet | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
- 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 way from home?

VOIDING SYMPTOMS:

- Do you have difficulty emptying your bladder completely?
- If yes, does it occur: all/most of the time half 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 the time some of the time
- Do you need to strain to empty?
- If yes, does it occur: all/most of the time half 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 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? YES NO

Do you lose urine with: YES NO

- Coughing YES NO
- Sneezing YES NO
- Lifting objects YES NO
- Straining YES NO
- Bending YES NO
- Walking YES NO
- During intercourse YES NO
- After intercourse YES NO

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? YES NO

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

In which positions does urine loss usually occur? Lying down YES NO

Sitting YES NO

Standing YES NO

Moving from sitting to standing position YES NO

Is your loss of urine a continual drip so that you feel constantly wet? YES NO

Do you ever lose urine without any warning or urge? YES NO

If yes, please explain when/how? _____

Do you lose urine without feeling it happen? YES NO

Do you lose urine while you sleep? YES NO

Do you wear protection for urine loss? YES NO

What type? _____ how many per day? _____

Do you experience hygiene or skin problems related to your leakage? YES NO

BLADDER PAIN:

Do you have discomfort associated with your bladder? YES NO

(if no, to above question, go directly to bowel section)

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 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 or surgery?) _____

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?

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)

Do you lose stool with:

Cough/sneezing	<input type="checkbox"/>	<input type="checkbox"/>
Aerobic Exercise	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/straining	<input type="checkbox"/>	<input type="checkbox"/>
Releasing gas	<input type="checkbox"/>	<input type="checkbox"/>
Urinating	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>

Is the amount you lose:
 Stain/smear 2 Tbsp or less ¼ to ½ cup ½ to 1 cup greater than one 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 your stool without feeling it happen?
 If yes, please explain when/how? _____

Does the stool loss, seepage or staining occur after bowel movement?
 Does the stool loss, seepage or staining occur 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 to 10 (0-none, 10-worst pain ever)

Before bowel movement	<input type="checkbox"/>	pain rating _____/10
During bowel movement	<input type="checkbox"/>	pain rating _____/10
After bowel movement	<input type="checkbox"/>	pain rating _____/10
With meals	<input type="checkbox"/>	pain rating _____/10
Other: _____	<input type="checkbox"/>	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 or surgery)?

PELVIC PAIN

YES NO

Do you experience pelvic pain? YES NO

(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? YES NO

If yes, indicate which of the following cause of pain 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? YES NO

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 YES NO

Bowel YES NO

Pelvic pain YES NO

Have you ever experienced Domestic violence YES NO

Rape YES NO

Sexual abuse/molestation YES NO

Date Rape YES NO

Incest YES NO

Have you ever been diagnosed with and/or treated for a nervous condition? YES NO

Have you ever been diagnosed with and/or treated for depression? YES NO

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	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	
First Name Used:	Address:
Middle Name:	Relationship to patient: _____
Address:	Date of Birth:
City: State:	Social Security No.:
Zip:	Phone: () _____ - _____
Home Phone:	
Work Phone:	Emergency Contact Information
Mobile Phone:	Name:
Legal Sex: Assigned Sex at Birth:	Relationship:
Gender Identity: Male____ Female____	Phone: Mobile Phone:
Transgender Male____ Transgender Female____	Employer information
Gender Non-conforming____ Self Identify	Employer:

Sexual Orientation: Heterosexual____ Homosexual____	Address:
Bisexual____	Phone:
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:	
Other	Pharmacy Information:
Patient Referred by:	Name:
Primary Care Provider:	Crossroads:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:
Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name:	Insurance Plan Name:
Last Name:	Last Name:
First Name:	First Name:
Middle Name:	Middle Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Date of Birth: Gender on Insurance (please circle): M or F	Date of Birth: Gender on Insurance (please circle): M or F
Employer Name:	Employer Name:
Patient's relationship to policy holder:	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 fully 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 its 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.

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Work Phone #:	May clinic staff leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mobile Phone #:	May clinic staff leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Email <input type="checkbox"/> Phone* <input type="checkbox"/> Text Message*
Appointment:	<input type="checkbox"/> Email <input type="checkbox"/> Phone* <input type="checkbox"/> Text Message*
Announcements:	<input type="checkbox"/> Email <input type="checkbox"/> Phone* <input type="checkbox"/> Text Message*
Billing:	<input type="checkbox"/> Email <input type="checkbox"/> Phone* <input type="checkbox"/> 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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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