Frederick Health

Welcome to Frederick Health Physical Therapy & Sports Rehab, offering Physical Therapy, Occupational Therapy, Speech Therapy, Pelvic Health Therapy, Lymphedema & Aquatic Therapy for both adults and pediatrics. Through evaluation and individualized treatment planning, our therapists will help you reach your rehabilitation goals and achieve your full potential. **You are the most important member of the treatment team!**

- To achieve the maximum benefits from your program, you must be an active participant in your program, and we ask that you attend all scheduled sessions.
- For ease of your treatment, please bring or wear loose comfortable clothing, bathing suit, eye glasses, and/or hearing aids.
- Please make every effort to be on time for your appointment. Your therapist may need to shorten your visit if you are late to avoid inconveniencing patients who follow. If you are more than 15 minutes late, we reserve the right to reschedule your appointment.
- Please call our office when you must cancel a scheduled appointment. **Failure to cancel a scheduled appointment** will be considered a **no show. PLEASE NOTIFY US 24 HOURS IN ADVANCE IF YOU CAN NOT MAKE YOUR APPOINTMENT. After three (3) no shows or cancellations, you may be discharged and your doctor will be notified.** If this occurs, you will need to return to your doctor for a new prescription to resume therapy.
- If you suspect that you may have or have been diagnosed with a communicable/infectious disease such as shingles, pink eye, strep throat, frequent or infectious diarrhea (sometimes called "C diff"), call the clinic prior to your appointment to discuss the appropriateness of your attendance with your therapist.
- Our staff makes every effort to make your treatment here a positive experience. To better assist you with the coordination of therapy as ordered by your physician, **we encourage you to know your outpatient therapy benefits.** Please take the time to review your benefit handbook or contact member services located on your member ID card.
- It is your responsibility to notify us of any changes in your insurance policy. Failure to provide accurate/ updated information may result in denial of coverage and you will assume financial responsibility.
- Please have family members and friends, unless a part of therapy, wait in the lobby. An adult **must** accompany children under 10 who are waiting in the lobby.
- **Co-payments are due at the time service is rendered and can be made at the registration desk.**

I Expect From My Therapist:

- _____
- _____
- _____

*Our Goal Is To Provide Excellent Service To **You***

Your feedback is very important in determining the effectiveness of your treatment. If you have questions, concerns or complaints, please discuss them with your therapist so adjustments can be made. We look forward to working with you.

_____ _____

Patient signature **Date** **Frederick Health Witness signature** **Date**

Frederick Health

What Brought You To Frederick Health Physical Therapy & Sports Rehab?

□ A family member or friend told me about Frederick Health Physical Therapy & Sports Rehab

□ I saw a flyer for Frederick Health Physical Therapy & Sports Rehab Services

□ I read a Frederick Health Physical Therapy & Sports Rehab article in *Frederick's Child* Magazine

□ I saw Frederick Health Physical Therapy & Sports Rehab information at Health Unlimited Family Fitness

□ I heard about Frederick Health Physical Therapy & Sports Rehab on the radio

□ I attended a Frederick Health Physical Therapy & Sports Rehab seminar/event

□ I found you online:

- □ Frederick Health Website
- □ Google Search
- □ Frederick Health Social Media

□ My Insurance recommended Fredrick Health Physical Therapy & Sports Rehab

□ I was a previous patient

□ My Physician referred me

Physicians Name_____

□ Another source? Please let us know!

Thank you!

Frederick Health

Pelvic Health Medical Questionnaire

Name _____ Date of Birth _____ Date _____

Physician _____ Occupation _____

Onset date of current medical problem _____

Please write the nature of your current medical problem: _____

_____

MEDICAL HISTORY: Circle all that apply

General Good Health	Asthma	Angina
Hypertension	Bronchitis	Fatigue
Osteoarthritis	Stroke	Headaches
Osteoporosis	Emphysema	Depression
Osteopenia	Seizures	Cancer
Low Back Pain	Weakness	Nausea
Shortness of Breath	Bruise Easily	Epilepsy
Hemorrhoids	Coughing	Tuberculosis
Abdominal Pain	Pacemaker	COPD
Skin Sensitivity	Heart Disease	Dizziness
Pelvic pain	Sexually transmitted disease	HIV/AIDs
Irritable Bowel Syndrome	Hepatitis	Anorexia/bulimia
Organ Prolapse	Endometriosis	Interstitial Cystitis

Other (specify) _____

SURGICAL HISTORY

Hysterectomy Abdominal	Date_____	Emergency Room	Date _____
Hysterectomy Vaginal	Date_____	Back Surgery	Date _____
Bladder Repair Abdominal	Date _____	Hernia Repair	Date _____
Bladder Repair Vaginal	Date _____	Gall Bladder Surgery	Date _____
Ovaries Removed	Date _____	Appendectomy	Date _____
D & C	Date _____	Kidney Surgery	Date _____
Other _____	Date _____		

PHYSICIANS

Obstetrician _____	Urologist _____
Gynecologist _____	Orthopedist _____
Primary Care Physician_____	General Surgeon _____

OBSTETRICAL HISTORY (females only)

Not Applicable _____	Currently Pregnant _____	Due Date _____
Number of Pregnancies _____	Difficult childbirth _____	
Number of Vaginal Deliveries _____	Painful periods _____	
Number of C-sections _____	Number of miscarriages _____	
Number of Episiotomies_____	Do you have a painful episiotomy scar? Yes ____No_____	

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MALES ONLY

Prostate Disorders_____ Erectile Dysfunction_____
Pelvic pain_____ Painful Ejaculation_____
Painful intercourse_____ Other/describe_____

GYNECOLOGY

1. Date of last pap smear_____ Normal? Yes _____ No _____
2. Date of last menstrual period_____
3. Have you ever had a sexually transmitted disease? Yes _____ No _____
   If yes, when? _____
4. Have you been sexually assaulted? Yes _____ No _____
5. Do you feel as if your organs are "falling out" Yes _____ No _____
6. Do you have trouble with pelvic pain*? Yes _____ No _____
   *If Yes, Describe _____
   *If No, Skip to question #15
7. Do you have pain with intercourse? Yes _____ No _____
8. Are you currently sexually active? Yes _____ No _____

Dyspareunia is a medical term that describes painful penetration, which is graded on 3 levels:

Level 1 – Penetration is painful, but sexual activity occurs with same frequency.
Level 2 – Penetration is painful, which limits sexual activity frequency.
Level 3 – Painful and prevents penetration.

Which level are you? _____

9. During painful penetration, do you feel (Please circle as many as apply):
   Burning stinging ripping pain friction
10. Do you feel pain with deep penetration? Yes _____ No _____
    Where is the pain? Vagina _____ Bladder _____ Back _____ Hips_____
    Other_____ Explain_____
11. Can you reach orgasm? Yes _____ No _____
12. Does it make the pain worse? Yes _____ No _____
13. Do you have pain, burning, or discomfort in the:
    Clitoris Yes _____ No _____ Labia Yes _____ No _____
    Vagina Yes _____ No _____ Anus Yes _____ No _____
14. How long has the pain been present? _____ How did the pain start? _____
15. Menopause? If no, skip to the next section Yes _____ No _____
    Have you been on Hormone Replacement Therapy (HRT)? Yes _____ No _____
    Are you currently on HRT? Yes _____ No _____ Dosage _____
    Type: Estrogen_____ Pills_____ Cream_____ Patch _____
    Progesterone_____
    Other _____
    If HRT was stopped, why? _____

Please answer all questions. Circle True, False, or Not Applicable

BLADDER SYMPTOMS

T	F	NA	I leak urine. If true, how long have you leaked urine? _____
T	F	NA	I have to wear pads because of urine loss. What kind of pads? _____
T	F	NA	Is the pad fully saturated when you change it? Yes _____ No _____
T	F	NA	My bladder problem is bad enough that I have asked/thought about asking my doctor about surgery.
T	F	NA	I urinate more than 8x/day.
T	F	NA	I urinate more than 2x/night.
T	F	NA	My urine stream is constant.
T	F	NA	My urine stream stops and starts.
T	F	NA	I have difficulty starting the urine stream.
T	F	NA	I dribble urine after using the restroom.
T	F	NA	After I urinate, I feel that my bladder is not completely empty.
T	F	NA	My urine loss is a continual drip, so that I am constantly wet.
T	F	NA	I leak urine when I cough, sneeze, laugh, or exercise.
T	F	NA	I lose urine in small amounts.
T	F	NA	I lose urine in large amounts and once it starts, I cannot stop the flow.
T	F	NA	I often feel the urge to urinate before I leak.
T	F	NA	I often leak when I am on the way to the bathroom.
T	F	NA	The sound/sight of running water makes me experience an urge to urinate.
T	F	NA	I have pain in the region of my bladder.
T	F	NA	It hurts to urinate.
T	F	NA	I often lose urine during intercourse.
T	F	NA	I have 2 or more bladder infections per year.

BOWEL SYMPTOMS

T	F	NA	I leak feces. If yes, how often? _____
T	F	NA	I have difficulty with passing gas when I don't want to.
T	F	NA	I have trouble with constipation.
T	F	NA	I use laxatives. If true, how often? _____What kind? _____
T	F	NA	I have 2 or more bowel movements per week.
T	F	NA	I have to "bear down" hard to have a bowel movement.
T	F	NA	I feel that my bowels are never fully empty.
T	F	NA	I have trouble with hemorrhoids.
T	F	NA	My bowel movements are painful.

What are your feelings about your current medical condition on a scale of 1 to 10?
0 1 2 3 4 5 6 7 8 9 10 No Impairment _____ Severe impairment _____

How long does it take you to drive to our office? _____

Frederick Health

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How and How Often You Take the Medication	Reason for taking	Date Started	Prescriber

Patient Signature_____ Date:_____

MR.RMMEDLIST

CONSENT FOR EVALUATION AND TREATMENT
OF PELVIC FLOOR DYSFUNCTION

I acknowledge and understand that I have been referred to Frederick Health Physical Therapy & Sports Rehab Pelvic Health Program for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include but are not limited to urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, and vulvar or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback. I understand that I can refuse the internal examination at any time by verbally informing the therapist not to proceed with or stop the examination. The physical therapist that will be performing the internal examination has had extensive additional education. Please feel free to contact the therapist if you have any questions/concerns prior to your initial evaluation at 240-215-1425.

Treatment may include, but not be limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

I understand that no guarantees have been or can be provided regarding the success of therapy. I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of Frederick Health Physical Therapy & Sports Rehab Pelvic Health Program.

Date: _____ Patient Name: _____
(Please Print)

_____
Patient Signature

_____
Signature of Parent or Guardian (if applicable)

_____
Witness Signature