Duffy & Bracken

WELLNESS & FITNESS • PHYSICAL THERAPY, P.C.

QUESTIONNAIRE FOR URINARY BOWEL CONTROL AND PELVIC FLOOR PAIN

(Check all that apply)

Medical History

❒ Arthritis	❒ Diabetes	❒ HIV
❒ High blood pressure	❒ Heart disease	❒ Herpes
❒ Lung/breathing problems/asthma	❒ Stroke	❒ Hepatitis
❒ Food allergies	❒ Hemorrhoids	❒ HPV
❒ Medication Allergies	❒ Osteoporosis	❒ Other virus
❒ Seasonal Allergies	❒ Cancer	❒ Chronic Fatigue Syndrome
❒ Leg pain	❒ Fibromyalgia	❒ Pelvic pain
❒ Low back pain	❒ GI dysfunction	❒ Do you smoke?
❒ Are you pregnant?	❒ Depression	❒ Other medical history/injuries:
❒ Have you been in major accidents or falls?	❒ Are you being treated with medication therapy?	_____ _____

Gynecological History

Number of pregnancies		
Number of vaginal deliveries		
Dates of vaginal deliveries		
Length of pushing		
Did you tear?	Y	N
Number of episiotomies		
Do you have a painful episiotomy scar?	Y	N
Number of C-sections		
Do you have a history of urinary track infections?	Y	N
When was your Menopause onset?		
Do you have a history of urine loss as a child?	Y	N
Do you have a history of urine loss as an adult?	Y	N
Do you have a history of urine loss after child birth?	Y	N
Do you use a diaphragm?	Y	N
Do you use tampons?	Y	N

Surgical History

❒ Back/neck surgery	❒ Gall bladder surgery	❒ Hysterectomy (abdom))
❒ Kidney surgery	❒ Appendectomy	❒ Hysterectomy (vaginal)
❒ Bladder repair	❒ Hernia	❒ Ovaries removed
❒ Other surgeries:		

Current Pain

Do you have pain with:

❒ Intercourse	❒ Ovulation (mid cycle)	❒ Contact with clothing
o Initial penetration	❒ Just before period	❒ Abdominal pain
o Deep penetration	❒ During period	❒ Sitting
o Erection	❒ After period	❒ Walking
o Ejaculation	❒ Full bladder	❒ Sleeping
o Orgasm	❒ While voiding	❒ Standing
o Arousal	❒ After voiding	❒ Other (explain)
❒ After intercourse	❒ Bowel movement	_____

Where is your pain currently? _____

What do you think is causing your pain? _____

Is there an event that you associate with onset of your pain? _____

If so, what? _____

Current Medication *(prescription, non-prescription)*

Have you been on Hormone Replacement Therapy?	Y	N
Dosage: ❒ Estrogen ❒ Progesterone	Type: ❒ Pills ❒ Patch/ring ❒ Cream	

Bladder

Do you:		
Experience an urge to urinate when you hear running water or as you enter your home and are you then unable to get to the toilet?	Y	N
Have difficulty initiating a urine stream?	Y	N
Have difficulty stopping your stream?	Y	N
Have pain with urination?	Y	N
Have burning with urination?	Y	N
Have blood in your urine?	Y	N
Have to strain to empty your bladder?	Y	N
Dribble urine while you are urinating?	Y	N
Dribble after you empty your bladder?	Y	N
Have a "falling out" feeling?	Y	N

Voiding Patterns

Voiding Frequency:	# of times/day		# of times/night
Incontinence:	# of episodes/day		# of episodes/night
Amount of urine lost: *(Check all that apply)*	Large ☐ Wet underwear ☐	Small ☐ Wet outer clothes ☐	Few drops ☐ Wet floor ☐

Urine loss caused by:	*Always*	*Sometimes*	*Never*
Laugh			
Cough			
Sneeze			
Walking			
Running			
Lifting			
Anxiety			
Urgency			
Intercourse			
Other: _____			

Daily Fluid Intake

How many cups of non-caffeinated/non-carbonated fluid are you drinking daily?
How many cups of coffee_____, caffeinated tea_____, soda_____, alcoholic beverages____ are you drinking daily?
Do you restrict fluids because of your incontinence?

Protective Devices

What type of protective devices do you use? (check all that apply)		
❒ Panty liner		
❒ Sanitary pad (mini)		
❒ Sanitary pad (maxi)		
❒ Incontinence pad (poise ☐ attends ☐ serenity ☐)		
❒ Incontinence brief		
How many pads do you use each day?		
Do you soak the pad fully?	Y	N

Previous Treatment for Incontinence

Have you done exercises to control urine loss (Kegels)?	Y	N
Has your doctor prescribed any medication to treat urine loss?	Y	N
Have you had any surgical procedures to treat urine loss?	Y	N

Bowel Habits

How often do you have a bowel movement?		
Are you ever constipated?	Y	N
How do you resolve constipation?		
Do you use laxatives?	Y	N
How often do you use laxatives?		
Do you use enemas?	Y	N
How often do you use enemas?		
Do you include fiber in your diet (fruit, veg, bran, etc.)?	Y	N
Do you experience diarrhea?	Y	N
Do you experience loss of feces unexpectedly?	Y	N

Mobility/Self-Care

Do you use a cane/walker?	Y	N
Do get regular exercise – please explain?	Y	N
Do you lean on furniture for balance?	Y	N
Do you have difficulty with getting on/off the toilet?	Y	N
Do you have difficulty getting clothes on/off?	Y	N
Do you have difficulty with toilet hygiene?	Y	N

Psychosocial Aspects

Do you live alone?	Y	N
What is your occupation?		
Do you do any recreational activities?	Y	N
What kind?		
Have you had to restrict your activities due to urinary incontinence?	Y	N
Do you empty your bladder frequently so that you stay dry?	Y	N
Have you had changes in intimate relationships/sexual functioning due to your symptoms?	Y	N

What are your feelings about your urinary incontinence on a scale of 1 to 10:

1	2	3	4	5	6	7	8	9	10

No impairment — Severe Impairment

What are your feelings about your pain on a scale of 1 to 10:

1	2	3	4	5	6	7	8	9	10

No pain — Worst Pain Imaginable

Are you sexually active now	Y	N
Do you have anal intercourse	Y	N
Have you experienced sexual or physical abuse in the past	Y	N
What are your rehabilitation goals/expectations?		

Signature: _____ Date: _____

Duffy & Bracken

WELLNESS & FITNESS · PHYSICAL THERAPY P.C.

DATE: _____

Home Phone: (____) _____

Work Phone: (____) _____

Cell Phone: (____) _____

Email: _____

Emergency Contact: _____

Emergency Phone: _____

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP _____

EMPLOYER: _____

ADDRESS: _____

JOB TITLE/OCCUPATION: _____

BIRTHDATE: ____/____/____ AGE: _____

SOCIAL SECURITY: _____ - _____-_____

MARITAL STATUS: _____ SEX: _____

HOW DID YOU HEAR ABOUT US? _____

To All Our Patients,

As you know, we are committed to providing you the very best physical therapy care. Unfortunately, Medicare and health insurance companies do not cover supplies that will be provided during your care. Due to increase in costs without increased reimbursements we can no longer absorb these fees. We will therefore be charging you for the costs of the supplies which are separate from any co-payment you may have. **Thank you for trusting us with your PT needs. It is truly our honor and privilege to serve you.**

Here is the list of supplies and costs:

1.	Probes	$60
2.	Taping	$5/session
3.	Kinesio tape	$5/session
4.	Electrodes	$10
5.	Heel raises	$10 each

SIGNED: _____

75 Maiden Lane, Suite 404 – New York, NY 10038 – Phone 212-402-5430 – Fax 212- 402-5432

Duffy & Bracken
PHYSICAL THERAPY, P.C.

FINANCIAL POLICY STATEMENT

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsibility.

If you provide our office with the necessary information regarding your insurance plan, we will submit our claim directly to your carrier. **You are responsible to pay the appropriate deductible, co-pays and/or coinsurance, also any denial of payments from your insurance.** We accept all major credit cards; however cash or check is preferred for services rendered. **It is the policy of this office to keep a credit card on file. Please provide credit card information below for any unpaid accrued charges.**

REGARDING INSURANCE

Physical therapy treatment can be provided without a prescription for the first 30 days or 10 treatments, whichever comes first but in some cases it may not be covered by your health care insurer without the referral of a physician or nurse practitioner, but may be a covered expense, if treatment was rendered pursuant to such referral.

If your plan requires authorization from your physician (primary or specialist), it is your responsibility to obtain the written referral or authorization prior to your visit at Duffy & Bracken. If you arrive at our office without proper authorization, full payment will be expected at time of service and refunded to you when authorization is obtained.

In addition, to comply with state regulations, you have to provide a prescription from your physician (primary care or specialist) within 30 days of the start of your treatment at Duffy & Bracken. Any denial of payment of services resulting from non-compliance with this policy will be billed to you.

Insurance is a contract between you and your insurance company. In most cases, we are NOT party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, coinsurance, co-payments, referrals, "usual & customary charges," etc., other than to supply factual information as necessary. If you have not paid Duffy & Bracken and your insurance company inadvertently pays you directly, you must send this payment immediately to Duffy & Bracken. **Please note we will collect payment via credit card following five business days of notification of your check sent directly to you.**

The above does not apply for those patients that are considered Worker's Compensation. However be advised if your claim for Workers Compensation benefits is denied you may be held responsible for the total amount of charges for services rendered to you.

Duffy & Bracken preferred Method of Payment for deductibles and co-payments are:

Cash: $_____ Check: _____ Money Order: _____

Co-pays, co-insurance, deductibles and fee for service must be paid at time of treatment. A $10 service charge will be added if not paid on the day of your appointment.

It is the policy of this office to keep a credit card on file. Please provide credit card information below for any unpaid accrued charges and/or fees.

Credit/Debit Card: _____ Card #: _____

Expiration date: _____

RESPONSIBLE PARTY SIGNATURE **DATE**

_____ _____