Physiotherapy

Pelvic Floor

HealthTweak

Patient # _____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Gender: _____ Employer: _____ Occupation: _____

E-mail: _____ May we contact you via e-mail? Y / N

Spouse/Partner: Y / N Children: Y / N #: _____

Medical Doctor: _____ Location: _____ Last Visit: _____

How did you hear about us? ☐*Existing patient* _____

☐*Online* ☐ *Doctor* ☐*Other:*_____

WHAT IS THE NATURE OF YOUR VISIT?

_____

_____

When did it begin? _____ Have you had this problem before? _____

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? _____

What does this challenge stop you from doing? _____

Have you seen anyone about this challenge? _____

Prior treatments and results? _____

HEALTH INFORMATION

Past injuries: (birth complication, teen trauma, emotional trauma, severe stress, injuries, work injuries, car accidents, surgeries, broken bones, etc)

Emotional trauma: _____

Chemical trauma: _____

Physical trauma: _____

Surgeries/Hospitalizations: _____

Health conditions treated for in the past year:

_____

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This is a gender-neutral form – please fill out all applicable sections and/or questions so your healthcare professional can better understand your symptoms.

Have you had any of the following medical procedures/surgeries?			
	Date		Date
Bartholin Cyst		Gallbladder	
Bowel Resection		Hemorrhoid Banding	
Laparoscopy		Mesh Procedure	
Cystoscopy		Prolapse/Vaginal Repair	
Colostomy/Ileostomy		Hysterectomy	
Hernia Repair		Colonoscopy	
Appendectomy		TVT-TOT	
CT/MRI		X-Ray/Ultrasound	
Prostatectomy		TURP	
Radiation		Green Light Laser	
Chemotherapy		Brachytherapy	
Urolift		HIFU	
Vasectomy		Urodynamics	
Other:			

Gynaecological History	Answers	
At what age did you start your period?		
Is your cycle regular?	Yes	No
How many days does your period last?	1 2 3 4 5+	
Is your bleeding heavy?	Yes	No
Do you have any pain with your period? PMS? Cramps?	Yes	No
Do you use tampons or menstrual cups?	Yes	No
Do you have pain with insertion of a tampon or menstrual cup?	Yes	No
Do you have a lot of vaginal discharge?	Yes	No
Do you use birth control?	Yes	No
Are you sexually active?	Yes	No
Do you have pain with sexual activity?	Yes	No
Do you engage in penetrative intercourse?	Yes	No
Do you have pain with intercourse?	Yes	No
Do you have pain after intercourse	Yes	No
Do you have pain at the opening of vagina with sexual activity?	Yes	No
Do you have deep pain in the vagina with sexual activity?	Yes	No
Do you participate in anal sex?	Yes	No

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Do you have pain with anal penetration?	Yes	No
Are you physically intimate with your partner without penetration?	Yes	No
Do you use lubrication with sexual activity?	Yes	No
Are you currently pregnant?	Yes	No
Are you currently breast/chest feeding	Yes	No
Have you had any miscarriages?	Yes	No
# Of pregnancies?	1 2 3 4+	
# Of C-sections?	1 2 3 4+	
# Of vaginal deliveries?	1 2 3 4+	
Weight of heaviest baby?		
Age of child(ren)?		
How long did you push during labour?	1 2 3 4+. (hrs)	
Did you have an epidural?	Yes	No
Did you have a vacuum-assisted delivery? Forceps delivery?	Yes	No
Did you have episiotomies? Tearing? Grade?	Yes	No
Did you feel supported and cared for during labour?	Yes	No

Were there times during labour and delivery that you felt in danger?	Yes	No
Do you suffer/have you suffered from post-partum depression/anxiety?	Yes	No
Have you gone through menopause?	Yes	No
When was your last menstrual cycle?		
Do you suffer from vaginal dryness?	Yes	No
Are you on any Hormone Replacement Therapy?	Yes	No
Do you use a vaginal moisturizer such Replens/Gynatrof/Repagyn?	Yes	No
Do you have feelings of heaviness/pressure in your vagina?	Yes	No
Do you physically feel something coming out of your vagina?	Yes	No
Have you ever been told you have a prolapse?	Yes	No
Do you have sensory changes/loss in your genitals?	Yes	No
Do you have a history of vulvar varicosities?	Yes	No

Fluid intake in a 24-hour period (approximately)	Cups/day
Number of cups of water per day	
Number of cups of other fluids/day (milk, juice, broth, soup)	
Number of cups of coffee/day	
Number of alcoholic drinks per day	
Number of cups of tea/day	
Number of carbonated drinks/day (pop, seltzer, carbonated water)	
Number of energy drinks/day	
Other:	

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Bladder Symptoms	Answers		
Do you have leakage with coughing, sneezing, laughing?	Yes	No	Sometimes
Do you leak with exercising, running or jumping?	Yes	No	Sometimes
Do you have leakage during intercourse?	Yes	No	Sometimes
Do you feel a strong urge to void but do not leak?	Yes	No	Sometimes
Do you leak after having a strong urge that feels uncontrollable?	Yes	No	Sometimes
Do you have pain when your bladder fills?	Yes	No	Sometimes
Does your pain improve when you void?	Yes	No	Sometimes
Do you have pain while voiding?	Yes	No	Sometimes
Do you have to strain in order to empty your bladder?	Yes	No	Sometimes
Do you have difficulty starting your urine stream?	Yes	No	Sometimes
Do you have dribbling after you urinate?	Yes	No	Sometimes
Do you sit on the toilet to void?	Yes	No	Sometimes
Do you feel fully empty after you void?	Yes	No	Sometimes
Do you lose bladder control during the night?	Yes	No	Sometimes
Does your incontinence fluctuate during your cycle?	Yes	No	Sometimes
Do you wear pads? Type?	Yes	No	Sometimes
How many pads do you use during the day?	1 2 3 4 5+		
Do you go to the bathroom more than 8 times per day?	Yes	No	Sometimes
How many times do you wake during the night to void?	0 1 2 3 4 5+		

Digestion and Bowel Function	Answers		
What is the frequency of your bowel movements? E.g., 1x/per day			
Do you regularly feel the urge to move your bowels?	Yes	No	Sometimes
Do you have constipation?	Yes	No	Sometimes
Do you strain to have a bowel movement?	Yes	No	Sometimes
Do you splint or assist to pass stool?	Yes	No	Sometimes
Do you use your finger to help evacuate stool?	Yes	No	Sometimes
Are you prone to having diarrhea/loose stool?	Yes	No	Sometimes
Do you have bowel urgency that is difficult to control?	Yes	No	Sometimes
Do you lose control of your bowels/accidental bowel leakage?	Yes	No	Sometimes
Do you have incomplete emptying after a bowel movement?	Yes	No	Sometimes
Do you have pain *with* a bowel movement?	Yes	No	Sometimes
Do you have pain *after* a bowel movement?	Yes	No	Sometimes
Does it take longer than 5 minutes to have a bowel movement?	Yes	No	Sometimes
Do you have abdominal cramps/pain/?	Yes	No	Sometimes
Do you have bloating (increased pressure in abdomen)	Yes	No	Sometimes
Does your abdomen feel distended when your bowels are full?	Yes	No	Sometimes

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In your opinion, is your fiber intake (Circle)? Too low - Adequate - Too high

Do you regularly use (Circle)? Laxatives – Stool softener – Natural Products – Enemas

Have your bowel habits changed recently including (Circle)?
Unexplained Weight Loss - Abdominal Pain - Rectal Bleeding - Excessive Straining

Have you ever been diagnosed with/think you have:	Answers	
Irritable bowel syndrome	Yes	No
Ulcerative Colitis	Yes	No
Crohn's Disease	Yes	No
Celiac Disease	Yes	No

Do you have any allergies (gel/vinyl) or food sensitivities/allergies? _____

Medical History	Answers		Notes
Urinary Tract Infections	Yes	No	
Recent antibiotics?	Yes	No	
Do you use probiotics?	Yes	No	
Do you use cranberry supplements?	Yes	No	
Do you smoke? Amount?	Yes	No	
Do you have a chronic cough?	Yes	No	
Do you get yeast infections?	Yes	No	
Do you get blood in your urine?	Yes	No	
Allergies?	Yes	No	What kind?
Do you exercise?	Yes	No	What type?
Low back problems?	Yes	No	
Mid back problems?	Yes	No	
Neck problems?	Yes	No	
Depression?	Yes	No	
Anxiety?	Yes	No	
Have you been diagnosed with a mental health condition?	Yes	No	

What physicians or health care providers have you seen for these problems?	
Physician/provider	Treatment provided

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Please list the medications you are currently taking (including vitamins and supplements)				
Medication/dose	Provider			
		Yes	No	Currently taking
		Yes	No	Currently taking
		Yes	No	Currently taking
		Yes	No	Currently taking
		Yes	No	Currently taking
		Yes	No	Currently taking

Is there anything else you would like to mention that might be important or relevant?

_____

_____

On a scale from 1-10, please circle and rate how much this problem bothers you?

1 2 3 4 5 6 7 8 9 10

On a scale from 1-10, please circle and rate how motivated you are to correct this problem?

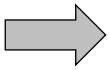
1 2 3 4 5 6 7 8 9 10

PERSONAL HEALTH INFORMATION CONSENT FORM

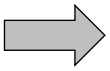
I understand that Health*Tweak* is my health information custodian. I consent to the collection, use and disclosure of my personal health information for treatment and other health care reasons. Health*Tweak* is a multidisciplinary clinic, and therefore treatment notes may be shared between practitioners to best treat the patient.

I understand that to provide me with Massage Therapy, Chiropractic, Physiotherapy, Naturopathic Medicine or any other health care services, Health*Tweak* will collect personal information about me (e.g. birth date, home contact information, health history, etc.)

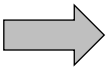
I understand that Health*Tweak* will only collect, use, or disclose my personal health information with my express or implied consent; unless a collection, use, or disclosure without consent is permitted or required by law.



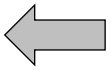
○ I give permission to HealthTweak to contact your primary healthcare provider such as my medical doctor, nurse practitioner ect.



Name: _____ Name of Witness: _____



Signature: _____ Date: _____



Thank you for completing this form.

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CONSENT TO PHYSIOTHERAPY ASSESSMENT AND TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your physiotherapist and to make an informed decision about proceeding with treatment.

Physiotherapy is a drug-free health care practice. Physiotherapists work in partnership with individuals of all ages to break down the barriers to physical function whether that means working with patients pre and post surgery, helping people come back from illness and chronic disease, injury, industrial and motor vehicle accidents and age-related conditions. Physiotherapists also play an important role in health promotion and disease prevention.

Physiotherapy treatment techniques may include, but are not limited to: manual therapy techniques including spinal and joint manipulation and mobilization, electrotherapeutic, thermotherapy or cryotherapy modalities and exercise. Other techniques such as functional dry needling, acupuncture and soft tissue therapy may also be utilized. A number of these may be recommended during your program of care.

Benefits

Physiotherapy treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Physiotherapy benefits include decreasing pain, improving joint mobility, increasing strength and coordination. It can also increase cardio-respiratory efficiency, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with physiotherapy treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Temporary muscle soreness –** techniques used may cause muscle soreness which usually only lasts a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar. Can also occur when pressure is applied to the skin or the use of needling technique.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention. This would be most prominent in patients with decreased bone density.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems occasionally.

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Physiotherapy treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, physiotherapy treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

Risks may include light bleeding, emotional response/anxiety, light headedness or nausea.

Risks Specific to Functional Dry Needling (FDN) and Acupuncture - The most serious risk with FDN or acupuncture is accidental puncture of a lung (pneumothorax) or other organs in the body. If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Health Tweak is a Multidisciplinary clinic; therefore other practitioners may have access to your file. If this poses any concern please let us know.

Alternatives
Alternatives to physiotherapy treatment may include consulting with other health professionals. Your physiotherapist may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the Physiotherapist's attention. If you are not comfortable, you may stop treatment at any time.

Please inform your Physiotherapist immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE PHYSIOTHERAPIST

I hereby acknowledge that I have discussed with the Physiotherapist the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to physiotherapy treatment as proposed to me.

_____
Name *(Please Print)*

_____ _____
Signature of Patient (or legal guardian) Date

_____ _____
Signature of Physiotherapist Date