

405 E Marshall | Gilmer, TX 75644 | OFFICE: 903-402-1052 | FAX: 888-335-2090

625 Chase Dr. Suite 101 | Tyler, TX 75701 | OFFICE: 903-717-8966 | FAX: 903-630-1893

PATIENT NAME: FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_ SEX: [ ] M OR [ ] F  
DATE OF BIRTH: \_\_\_\_\_ MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME #: \_\_\_\_\_ CELL #: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_ EMPLOYER NAME & PHONE: \_\_\_\_\_  
REFERRING PHYSICIAN: \_\_\_\_\_ PRIMARY PHYSICIAN: \_\_\_\_\_  
WHO MAY WE CALL IN CASE OF AN EMERGENCY: \_\_\_\_\_ PHONE: \_\_\_\_\_  
HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

ARE YOU CURRENTLY ENROLLED IN **HOME HEALTH** OR HAVE YOU BEEN IN THE LAST 30 DAYS? [ ] YES [ ] NO

## Pelvic Floor Consent for Treatment and Attendance Agreement

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunction includes, but is not limited to urinary or fecal incontinence, difficulty with bowel, bladder or sexual function, painful scars after childbirth or surgery, sacroiliac disorders, low back pain, or pelvic pain.

I understand that to evaluate my condition, it may be necessary, initially or periodically, to have my therapist perform an internal pelvic floor exam. This is performed by observing and/or palpating digitally externally or internally the vagina or rectum and/or surrounding areas of the pelvic floor. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatments may include the following: observation, palpation, use of vaginal/rectal sensors, heat, cold, stretching, strengthening exercises, soft tissue massage or mobilization, and educational instructions.

I understand and agree that for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. I understand that if I do not show 2 appointments, I will be discharged from therapy services for non-compliance.

1. The purpose, risks, and benefits of pelvic floor physical therapy have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that if I can not make my scheduled appointments, I will notify The Pelvic Fixx within 24 hours of my appt time.

Patient Signature: \_\_\_\_\_ Staff Initials: \_\_\_\_\_ Date: \_\_\_\_\_

# HIPAA – Release of Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Release of Information

I authorize the release of information including the diagnosis, records; examination performed, treatment rendered to me, appointment scheduling, and claims information. This information may be released to:

Spouse \_\_\_\_\_

Child(ren) \_\_\_\_\_

Other \_\_\_\_\_

Information is **NOT** to be released to anyone

**This Release of Information will remain in effect until terminated by me in writing.**

## Contact by calling my:

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Work: \_\_\_\_\_

## If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

\_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Legal Representative or Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name and Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT QUESTIONNAIRE: MALE PELVIC FLOOR**

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_

Have you received previous Physical Therapy for this problem? (circle) No OR Yes: (date): \_\_\_\_\_

Have you received other treatment for this problem? No OR Yes: (type) \_\_\_\_\_

**Medical History (circle all that apply):** heart problems / hypertension / diabetes / cancer / seizures  
thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis  
rheumatoid arthritis / hx of stroke / kidney problems / depression / osteoporosis / hx of blood clots/DVTs  
Other: \_\_\_\_\_

**Surgical History (list type & date):** \_\_\_\_\_  
\_\_\_\_\_

**Pelvic History (fill in blanks or circle answer for all that apply):**

History of Benign Prostatic Hyperplasia? No OR Yes: (specify date(s) and any treatments received)  
\_\_\_\_\_

History of prostate cancer? No OR Yes: (specify date(s) and treatments) \_\_\_\_\_  
\_\_\_\_\_

History of hemorrhoids or other colorectal problems? No OR Yes: (specify date(s) and treatments)  
\_\_\_\_\_

History of sexually transmitted diseases: No OR Yes: (specify active infections) \_\_\_\_\_

History of chronic urinary / bladder infections? No OR Yes: (specify) \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Work Status:**  currently working  retired  temporarily off work  unemployed  other:

**Location / type of work:** \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Daytime phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How did you learn about us?  friend  physician  internet  advertisement  other:

Date of your next doctor's appointment: \_\_\_\_\_

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

## MALE PELVIC FLOOR REHAB: SYMPTOM QUESTIONNAIRE

### Urinary Symptoms: Check all that apply and fill in appropriate blanks.

- Urgency (experiencing unusually strong urges to urinate that may come on suddenly)
- Frequency: urinate \_\_\_\_\_ times per (circle one) hour / day.
- Leaking: When I leak, it (circle all that apply):  
     dampens underwear /  dampens outerwear /  empties my bladder completely.
- Leaking: I leak with (circle all that apply): a strong urge to urinate / lifting / coughing  
laughing / sneezing / bending / standing up / opening door to house / parking car  
on way to bathroom / walking / jogging/exercise / hear running water / dribble after urination  
other: \_\_\_\_\_
- Leaking: I leak \_\_\_\_\_ times a (circle one): day / week.
- Leaking: I cannot tell when I leak; sometimes it feels like I constantly leak.
- Use of leakage protection (number per day): thin liner \_\_\_\_\_ / pad \_\_\_\_\_ / diaper \_\_\_\_\_
- Wake at night to urinate: number of times each night: \_\_\_\_\_
- Burning with urination
- Abnormal stream (specify: \_\_\_\_\_)
- Difficulty or hesitancy with emptying bladder

Other: \_\_\_\_\_

### Fluid Intake: Fill in average number of cups (1 cup=8 ounces) of intake of each of the following per day:

- Water                       Milk                       Juice (specify: \_\_\_\_\_)
- Soft Drinks                 Decaf Soft Drinks     Tea
- Decaf Tea                  Coffee                  Decaf Coffee
- Alcohol                     Other: \_\_\_\_\_

### Bowel Symptoms: Check all that apply and fill in blanks.

- Number of bowel movements per (circle one) day / week : \_\_\_\_\_
- Constipation: Do you frequently strain to move bowels because of this? Yes OR No
  - Take regular fiber supplements (type and frequency): \_\_\_\_\_
  - Frequent diarrhea
  - Irritable bowel syndrome
  - Lactose intolerance or other food allergy affecting bowels (specify other: \_\_\_\_\_)
  - Bowel leakage (circle all that apply): stains underwear / small amount / large amount  
/ leak with lifting / coughing / laughing / sneezing / bending / standing up / walking /  
jogging/exercise / sexual intercourse / other: \_\_\_\_\_
  - Bowel leakage: I leak \_\_\_\_\_ times a (circle one) day / week.
  - Use of leakage protection (number per day): panty liner \_\_\_\_\_ / pad \_\_\_\_\_ / diaper \_\_\_\_\_

Other: \_\_\_\_\_

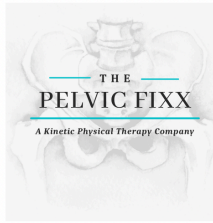
### Pain Symptoms:

- Do you have pain? No OR Yes: location: \_\_\_\_\_
- Describe how the pain feels: \_\_\_\_\_
- How long has pain occurred: \_\_\_\_\_
- Are any of your normal activities limited by pain? No OR Yes: (specify) \_\_\_\_\_
- What makes your pain worse?: \_\_\_\_\_
- Better?: \_\_\_\_\_

Rate your pain on the following scale: 0=no pain at all, 5=moderate pain, 10=worst pain imaginable

At worst (circle one): 0 1 2 3 4 5 6 7 8 9 10                      On average: 0 1 2 3 4 5 6 7 8 9 10

**Goals you want to achieve through therapy (be specific):** \_\_\_\_\_



## CANCELLATION and NO SHOW POLICY

We have updated our Cancellation and No Show Policy. This will become effective on **February 1, 2025**.

By signing below, you authorize knowledge of this information and agree to comply with our policy.

### Cancellation Policy:

I understand that a 24 hour notice **MUST** be given to The Pelvic Fixx either by email or phone. Calls received after 4 pm prior to the day before your appointment will not be answered until the next business day. Therefore, a voicemail must be left in order to comply with this policy. Cancellations less than 24 hours notice **will be charged a \$50.00 fee** which will be collected prior to the next scheduled appointment.

### No Show Policy:

I understand that if I No Show/No Call for my scheduled appointment, I will also be charged a **\$50.00 fee. If I No Show/No Call 2 appointments, I give The Pelvic Fixx the authority to remove any future scheduled appointments and to discharge me from their care due to non-compliance of this policy.**

**\*\* ONLY TEXT MESSAGE REMINDERS WILL BE SENT.\*\***

**\*\* REMINDER PHONE CALLS WILL NO LONGER BE AVAILABLE.\*\***

If you are more than 15 minutes late, The Pelvic Fixx reserves the right to refuse care due to limited availability and 1 hour time slots.

Your compliance with this policy only helps The Pelvic Fixx provide you with the best care possible in the most timely manner. Thank you for your understanding and we look forward to working with you!!!

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Phone: Tyler - 903-717-8966 or Gilmer - 903-402-1052

Email: [thepelvicfixx@gmail.com](mailto:thepelvicfixx@gmail.com)

