PRE-EVALUATION QUESTIONNAIRE: MALE VERSION

Please remember to bring in completed forms to your first appointment.

Name _____ Date of Birth _____ Age _____

Address _____ City/State/Zip _____

Home Ph _____ Cell Ph _____ Email _____

Employer Name _____ Occupation _____

Emergency Contact Name/Phone Number _____

Referring Provider Name/Clinic: _____

If no referring provider, how did you hear about us? Facebook / Google / Friend-Family / Website/

Insurance Portal / Other: _____

Primary Care Provider Name/Clinic: _____

Please List your Primary Complaints	**Goals for Therapy**
1.	1.
2.	2.
3.	3.

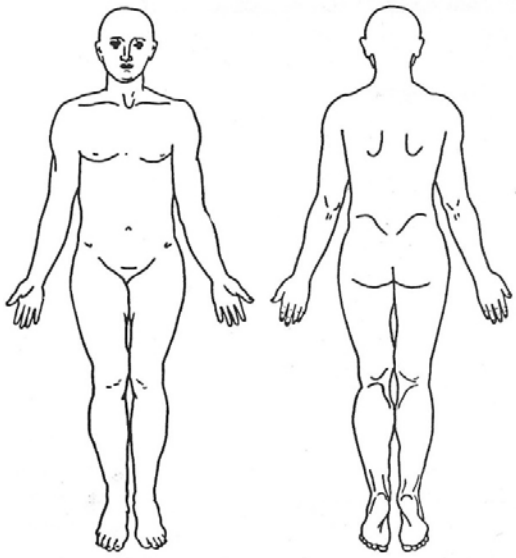
What do you do for exercise (mode, frequency, duration)? _____

_____

_____

Discomfort Feedback

On the diagram below, please indicate the area where you are experiencing the symptoms that you are seeking treatment for today.



What makes your pain better? _____

What makes your pain worse? _____

How would you describe your pain? *(circle as many as apply)* **Worse in AM Worse in PM Sharp Burning Dull/Achy Throbbing Shooting Numbness/Tingling Constant Intermittent**

Are you experiencing any **weakness**, **numbness**, **tingling** or **pins/needles sensation**? *(circle as many as apply).* If so, where? _____

Have you had any unexpected weight loss or weight gain? **Yes No** Explain _____

Any history of trauma or abuse? **Yes No**

Bladder

Please list your daily fluid intake (in ounces):

Clear Liquid: _____ Caffeine: _____ Alcohol: _____

Time between voiding (can be a range): AM _____ PM _____

How many times do you empty your bladder in a 24-hour period? _____

How many times do you get up at night to empty your bladder? _____

Bowel

How often do you have a bowel movement? _____

Most common stool consistency *(please circle*): **Liquid** **Soft** **Firm** **Pellets**

Do you feel like you can fully empty your bowels? **Yes** **No**

Do you experience pain or discomfort with bowel movement? **Yes** **No**

Sexual Activity *(please circle)*

Do you have pain with erection? **Yes** **No**

Do you have pain with ejaculation? **Yes** **No**

Do you have pain with penetration? **Yes** **No**

...with initial penetration? **Yes** **No**

...with deeper penetration? **Yes** **No**

...with certain positions? _____

Medical History

Please circle current (C) or previous (P) and yes or no for any relevant diagnoses.

Bladder Infections	**C**	**P**	Osteoporosis/Osteopenia	**C**	**P**	Cysts/Fibroids	**C**	**P**
Prostate Infections	**C**	**P**	Respiratory Problems	**C**	**P**	Depression/ Anxiety	**C**	**P**
Hemorrhoids	**C**	**P**	Allergies/Sinusitis	**C**	**P**	Digestive Problems	**C**	**P**
Diabetes	**C**	**P**	Cardiovascular Disease	**C**	**P**	Sexually Transmitted Infection	**C**	**P**
Cancer	**C**	**P**	Thyroid Problems	**C**	**P**			
Other:								

Orthopedic Problems: _____

_____

_____

History of surgeries *with* approximate dates: *(please circle)*

ABDOMINAL/PELVIC	HIP	LOW BACK
Laparoscopy	Labral Repair/Reconstruction	Fusion
Appendectomy	Total Hip Arthroplasty	Laminectomy
Hernia Repair	Arthroscopy	Microdiscectomy
Other:	Other:	Injections
		Other:

Diagnostic tests completed relevant to your symptoms and/or your spine/hip/pelvic region *with* approximate dates. If you have a copy of the report, please bring that with you.

_____

_____

_____

Medication and Supplement History

List all medications, nutritional supplements, and over the counter drugs you are *currently* taking.

_____

_____

_____

_____

INFORMED CONSENT FOR EVALUATION AND TREATMENT

I understand that with referral to physical therapy for a pelvic floor dysfunction and/or biofeedback, it may be beneficial for my therapist to perform a *muscle assessment of the pelvic floor.* Palpation of these muscles is most direct and accessible if done via the rectum/vaginal canal.

I understand that the benefits of the vaginal/rectal assessment will be explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will notify my physical therapist and the procedure will be discontinued and alternatives will be discussed with me. The therapist will explain all procedures to be used in my treatment, and I may choose not to participate with all or part of the treatment plan.

Treatment procedures for pelvic floor can include biofeedback, electrical stimulation, and/or manual techniques such as massage or soft tissue work.

Based on the information I have received from the therapist, I voluntarily agree to the standard assessment and treatment plans for my condition.

Signature of Responsible Party Date

If you are currently having an infection of any kind, or have a, sensitivity to KY jelly or vinyl gloves, please inform the therapist prior to the pelvic floor assessment.

HIPAA PRIVACY NOTICE

If you have questions and/or would like additional information regarding the uses and disclosures of your health information, you may contact our Privacy Officer at:

Pelvic Therapy Specialists, PC
777 29th Street, Suite 102, Boulder, CO 80303
Phone: (303) 601-7495 Fax: (888) 433-8309

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201. Complaints filed directly with the secretary must be made in writing, name us, describe the acts or omissions in violation of the privacy rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted to us must be in writing and to the attention of our Privacy Officer. There will not be retaliation for filing a complaint.

By signing below, I hereby acknowledge receipt of this privacy notice.

Print Name

Signature of Responsible Party Date

Office Use Only:
After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s) _____

Pelvic Therapy Specialists Representative Signature Date

CANCELLATION AND NO-SHOW POLICY

We are committed to exceptional patient service and clinical care to expedite the healing and recovery process. To accomplish this, it is extremely important that you attend each of your scheduled appointments.

- **Scheduling** is based on a first come, first served basis. It is advisable for you to schedule your appointments in four to six week intervals (if needed) to ensure treatment continuity, as schedules are **commonly booked** for the immediate two weeks.
- In the event that you need to cancel an appointment, **we request at least 24 business hours notice**. Cancellation less than 24 hours can mean that we may not be able to schedule another patient who may be in need of our services.
- In the event of a late cancellation or "no-show," **your account will be assessed a $90 cancellation fee.** This charge will **not be covered by insurance** but will have to be paid by you personally**.** By signing below you **authorize permission for Pelvic Therapy Specialists to run your credit card** at the time.
- We understand that emergencies do occur – late cancellation due to severe weather, illness and family emergency is excluded from this policy. For women, internal treatment while having a period is common. Additionally, we may be able to work on secondary areas that may be a part of your pain and/or symptoms.
- **Arriving on time for your appointment is critical** to the optimal delivery of care. Chronic late arrivals are disruptive to the successful implementation of your patient care plan. Appointment times will still end at the scheduled time regardless of what time you arrive.

I understand the terms of this form. I agree to be financially responsible to pay for charges incurred from cancellations made less than 24 hours or no shows. I authorize Pelvic Therapy Specialists, PC to charge my credit card in the event of a cancellation or no show.

Signature of Responsible Party Date

INSURANCE WAIVER FORM FOR CASH PAY PATIENTS

I have opted to not to use my out of network health insurance benefits (if available) to obtain a discounted cash pay rate.

I waive the ability to submit claims and bills retroactively to my health insurance company for physical therapy services rendered by Pelvic Therapy Specialists, PC.

In order to process payments efficiently, we will request a copy of your Credit Card at your first visit. Information will be kept secure in accordance with credit card industry regulations. I understand that I am responsible for any amount not covered by insurance. All professional services rendered are charged to the patient. Your remittance is due upon receipt of your bill. The charges and statement will be emailed around the 30th of the month. Around the 10th of the month after the statement has been emailed, the card on file will be charged. If a transaction is rejected, any account balance outstanding longer than 28 days will be charged a **$10 re-bill fee** for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.

I have received a copy of Pelvic Therapy Specialists, PC financial policy and understand its content. Pelvic Therapy Specialists has my permission to put my Health Savings Account or Credit Card(s) on file. I understand that my card will be charged if my insurance says I am responsible for a deductible or co-insurance after my insurance adjustments. **PATIENTS ARE RESPONSIBLE TO CHECK EXPLANATION OF BENEFITS. THAT IS THE AMOUNT WE WILL BE CHARGING YOUR CARD.** Failure to make payment when requested is basis for legal action and the undersigned agrees to pay all costs of collection including a reasonable fee and hereby waive their right of exemption under the law of the State of Colorado and any other state.

Signature of Responsible Party Date