LAWTON WOMEN'S CLINIC

New Patient Paperwork - PFT

Legal Name: _____ Preferred Name: _____

DOB: _____ Social Security Number: _____-_____-_____

Mailing Address: _____ Zip Code: _____

Phone: _____ Can we text you? ☐ Yes ☐ No

Email address: _____Can we email you? ☐ Yes ☐ No

Who referred you to us? _____

Pharmacy Name: _____ Phone: _____

Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex

Preferred pronouns: ☐ She/her ☐ He/him ☐ They/them ☐Other _____

Please list any drug allergies and their reactions: _____

_____

Please list any medications you are currently taking (include drug, dose, & frequency):

_____

_____

_____

_____

_____

Briefly describe the problem that brought you in today, how it began, and when:

_____

_____

_____

Rate the severity of the problem on a scale of 0-10 (a 10 affects your quality of life): _____

If pain is present, rate your current pain on a scale of 0-10 with 10 being the worst pain: _____

What makes your symptoms worse? _____

_____

Is there anything you've found that relieves your symptoms? _____

_____

Was your first episode of the problem related to a specific incident? ☐ Yes ☐ No

If yes, explain: _____

_____

Since that time, the problem is: ☐ Getting worse ☐ Getting better ☐ Staying the same

Describe previous treatments/exercises: _____

_____

Please indicate what you would like to achieve through therapy: _____

_____

Please indicate any concerns you have about receiving therapy: _____

_____

Are there any beliefs, values, or customs that the clinician needs to consider when treating you?

_____

Medical & Social History

Please check if you have ever had any of the following:

____ Fibromyalgia

____ Lupus

____ Low back pain

____ SI joint dysfunction

____ Osteoarthritis

____ Chronic fatigue syndrome

____ Depression/anxiety

____ PTSD

____ Sexually transmitted infection

____ Physical/sexual trauma

____ Bowel/bladder dysfunction

____ Painful bladder

____ Leakage of urine or stool

____ Irritable bowel syndrome

How would you rate your physical health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Rate your current level of stress: ☐ Low ☐ Medium ☐ High

Occupation: _____ Hours/week _____

Activity/exercise _____ Times/week Type _____

Indicate history by checking all that apply:

☐ Vaginal deliveries _____
☐ C-sections_____
☐ Episiotomies _____

☐ Vaginal dryness
☐ Pelvic pain
☐ Painful periods

☐ Pain with vaginal insertion
☐ Organ prolapse

Bowel and Bladder Symptoms

☐ Trouble starting urine stream
☐ Slow or intermittent stream
☐ Trouble stopping urine stream
☐ Trouble emptying bladder
☐ Straining/pushing to urinate
☐ Trouble feeling urge/fullness
☐ Dribbling after urination

☐ Urinary leakage
☐ Painful urination
☐ Painful bowel movements
☐ Trouble holding back gas
☐ Recurrent UTIs
☐ Constipation/straining
☐ Abdominal Bloating

Frequency of urination **Awake hours** _____ times per day **Sleep hours** _____ times per night
When you have a normal urge to urinate, how long are you able to delay before you have to use the toilet? _____ minutes _____ hours or ☐ I can't wait
The usual amount of urine passed is ☐ Small ☐ Medium ☐ Large
Indicate average fluid intake (one cup=8 oz) _____ cups/day How many are caffeinated? _____

Frequency of bowel movements _____ times per day _____ times per week
When you have an urge to pass stool, how long are you able to delay before you have to use the toilet? _____ minutes _____ hours or ☐ I can't wait
If constipation is present, please describe management techniques _____

_____

Do you have the feeling of organ "falling out"/prolapse or pelvic heaviness/pressure? Yes No
☐ With standing for _____ minutes or _____ hours ☐ With exertion/straining

IF NOT EXPERIENCING LEAKAGE/INCONTINENCE OF BLADDER/BOWEL, PLEASE SKIP SECTION

I am experiencing bladder leakage ☐ Yes ☐ No ☐ Only with physical exertion/cough
Number of episodes _____ times per day _____ times per week _____ times per month
On average, how much urine do you leak? ☐ a few drops ☐ Wets underwear
☐ Wets outerwear ☐ Wets floor

I am experiencing bowel leakage ☐ Yes ☐ No ☐ Only with physical exertion/strong urge
Number of episodes _____ times per day _____ times per week _____ times per month
On average, how much stool do you lose? ☐ Stool staining ☐ Small amount in underwear
☐ Complete emptying

INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION

During the evaluation for the problems you have reported, an assessment of your pelvic floor will be performed in order to identify any musculoskeletal problems. In order to evaluate your condition, it may be necessary, initially, and periodically, for the clinician to perform an internal pelvic floor muscle examination. This examination is performed by observing and/or 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.

You have the right to refuse any treatment modality, and your clinician can assess and treat the pelvic floor muscles externally if needed. The assessment of the pelvic floor muscles may result in soreness or discomfort temporarily. If this occurs, please discuss your symptoms with your clinician. We realize that many patients may be apprehensive because of the private nature of the condition and the nature of the examination. Please ask as many questions as you need to increase your comfort and understanding of your evaluation, its findings, and treatment. Please discuss any concerns or hesitation that you may have with your clinician. By signing this form, you agree and understand that treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat as discussed. You are always free to change your mind at any time during your course of treatment, and you are encouraged to notify your clinician of any changes of your preferences.

Please initial each line and sign below:

_____The purpose, risks, and benefits of this evaluation have been explained to me.

_____I understand that I can terminate the evaluation or examination at any time.

_____I understand that I am responsible for immediately telling the examiner if I am having discomfort or unusual symptoms during the evaluation.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

_____ _____

Signature of legal guardian or authorized representative Date