CREATIVE THERAPEUTICS
PHYSICAL THERAPY

2763 E. Shaw Ave. Suite #102 | Fresno, CA 93710 | (559) 294-8112 | Fax (559) 294-7805

Sandra Bausman, PT, WCS

Nancy Larson, PT, WCS

Kimberley K. Voelz, PT, DPT

Welcome to Creative Therapeutics Physical Therapy. Your appointment has been scheduled on: _____
Please arrive 10 minutes before your appointment time. Thank you.

Please Note:

1. It is this office's protocol to have an RX/Referral from your doctor or dentist according to the diagnosis you will be treated for, in order for your visits to be processed through your health insurance.

2. If you are receiving physical therapy treatment at another Clinic, please arrange these appointments on different days when you have your appointment here. It can affect how your insurance plan may or may not pay if you have two physical therapy sessions on the same day.

As a courtesy to others with allergy sensitivities, we kindly ask you to please refrain from wearing colognes or perfumes during your visit here.

A fee of $75.00 will be charged for failure to cancel an initial evaluation appointment without a 24 hour notice. A fee of $50.00 will be charged for failure to cancel a follow-up appointment without a 4 hour notice.

If you have any questions, please feel free to call our office.

Thank you.
Creative Therapeutics Physical Therapy

MAP ON REVERSE SIDE

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Women's Health Physical Therapy

What is pelvic floor physical therapy?

Pelvic floor physical therapy is a specialized area of PT that addresses pelvic floor dysfunction. Two main types of pelvic floor dysfunction exist; the first involves weakness of the pelvic floor muscles resulting in incontinence and the second involves pelvic floor muscle spasms that result in pain and possibly incontinence.

What is the pelvic floor?

The pelvic floor is a group of skeletal muscles that is the bottom of your inner core. These muscles are located at the bottom of the trunk and run from the pubic bone to the tailbone wrapping around the vaginal and rectal openings. The pelvic floor has 4 primary functions that are extremely important in life. These functions are:

1. Supportive: These muscles act to support all the pelvic organs (the bladder, urethra, uterus, vagina and the rectum).
2. Stabilization: If your pelvic floor muscles become weak you can develop compensatory patterns of movement and substitute inappropriate muscles which can lead to faulty movement patterns and possibly pain.
3. Sphincteric: These muscles help prevent the involuntary loss of gas, urine, or bowel.
4. Sexual functioning.

What are common complaints with pelvic floor dysfunction?

Examples of typical complaints include:

- Involuntary loss of urine or stool
- Deep pain in the low back that can radiate to the abdomen, groin, hips and/or legs
- Vaginal pain and or pain with sex
- Pain with urination, bowel movements, sitting, standing or walking
- Urinary urgency and frequency
- Rectal pain
- Pelvic pressure or a falling out feeling

What should you expect?

On your first visit a thorough evaluation will be completed. Evaluations include thorough history taking, postural assessment, range of motion measurements, palpation of key muscles of the pelvis and surrounding areas, strength testing, and analysis of movement patterns and structural alignment of the body. Often times it is necessary to complete an internal pelvic exam to assess the pelvic floor musculature. Once this is completed, all of the evaluation findings will be discussed with you, goals are set and treatment approaches are determined.

How is pelvic floor dysfunction treated?

Specific treatment approaches used by pelvic floor physical therapists may vary according to the dysfunction determined by the evaluation. These approaches include but are not limited to the following:

1. Manual Therapy: Manual therapy may be used to realign the bones of the pelvis or spine. It is also used to release tension in the muscles that attach to the pelvis, including the pelvic floor muscles. Techniques such as myofascial release, trigger point release, soft tissue mobilization and scar mobilization, if applicable are commonly used. When it is found that internal restrictions are present, whether it be a muscle spasm, scar tissue, fascial restriction or weakness, the same techniques can be used internally.
2. Strengthening: If it is determined that there is weakness present which is typically the case with incontinence, then this is addressed with a specific exercise program tailored to meet the needs and abilities of each individual.
3. Neuromuscular re-education with biofeedback: Biofeedback is a mechanism where you can monitor how much electrical activity is being generated by the pelvic floor muscles. The goal is to get the pelvic floor muscles to fire with proper timing and force. A patient is taught specific Kegel exercises while being monitored via a connection to a computer through the use of a vaginal or rectal sensor. Biofeedback can also be used to help a patient learn how to stop the pelvic floor from being in spasm. Objective feedback on a monitor facilitates this relaxation process.
4. Patient Education and home program: Education is probably the most important element of your therapy. You will be taught how and why your problem developed as well as prevention of further dysfunction. In order to achieve long term carryover of this type of therapy, you will need to be an active participant by following through with an individualized home exercise program that will be taught to you.

Financial Policy

Communication with our clients regarding our financial policy assists us in providing the best possible service to you. Please read the following. Your signature is required at the bottom of the page.

PRIVATE PAY – Full payment is required when services are rendered to continue treatment.

DEDUCTIBLE, CO-PAYMENT AND/OR CO-INSURANCE – We will be contacting your health insurance to verify your coverage. It is important to remember that what the insurance company tells us is not a GUARANTEE of payment from them. All dates of service are billed promptly; however, you are responsible to pay in advance for your deductible if it has not been met. Co-payment and/or co-insurance are required to be paid at the time of service.

PURCHASING PRODUCTS – Payment for all products is the patient's responsibility and due at time of purchase.

Agreement To Pay

_____I understand that the Agreement with my insurance company is an Agreement between them and me. I take full responsibility for payment of all charges for professional services rendered. I understand the financial policy outlined above. I understand that I am responsible for all charges regardless of my existing medical coverage. (Please initial above if you understand these statements).

Consent for Treatment / Release of Insurance Assignment Medical Information:

YES____NO____I authorize the therapy services that the provider feels necessary or advisable in conjunction with my referral.

YES____NO____I assign payment of medical benefits directly to Creative Therapeutics P.T., Inc. (C.T.P.T., Inc.)

YES____NO____I hereby authorize C.T.P.T., Inc. to release to my insurance company or medical provider any medical records or information concerning the treatment to obtain reimbursement on my behalf for the treatment or service provided by C.T.P.T., Inc. I understand that I may revoke the consent to release information to third parties at any time and that the provision of services is not conditioned on my agreement to disclose information to the parties. If I revoke my consent, I will be responsible for paying all services rendered by C.T.P.T., Inc.

I have read, understand and agree to this financial agreement.

SIGNATURE DATE

CREATIVE THERAPEUTICS
PHYSICAL THERAPY

Office No-Show and Late Arrival Policies

No-Show/Late Cancellations: Appointment time slots are precious and very much in demand for our office. In an effort to serve you better, we ask for proper notice for any cancellation. **Patients failing to provide at least a 24-hour notice will be charged $75.00 for the initial evaluation. Follow-up visits not cancelled 4 hours prior will be subject to a late cancellation fee of $50.00.**

Late Arrivals: We make every effort to be on time for all our appointments. Unfortunately, when even one patient arrives late, it can throw off the entire schedule for that session. In addition, rushing or "squeezing in" an appointment shortchanges the patient and contributes to decreased quality of care (and increases medical errors). In light of this, at the discretion of the treating therapist, **patients arriving more than 10 minutes late may be asked to reschedule for another day or may be offered another appointment time the same day if there is one available. The late arrival to the appointment will be considered a no-show, therefore the $50.00 fee will apply and will have to be paid before the next appointment.**

In addition, we reserve the right to terminate treatment after two no-shows, two late cancellations or three late arrivals.

I have read, understand and agree to this no-show, late cancelation and late arrival policy.

SIGNATURE DATE

Patient Information Consent Form

I have read and fully understand *Creative Therapeutics Physical Therapy, Inc.*'s Notice of Information Practices. I understand that *Creative Therapeutics Physical Therapy, Inc.* may use or disclose my personal information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services probed and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that *Creative Therapeutics Physical Therapy, Inc.* will consider requests for restrictions on a by case bases, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in *Creative Therapeutics Physical Therapy, Inc.'s* Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I have requested and/or been given a copy of *Creative Therapeutics Physical Therapy, Inc.'s* Notice of Information Practices, which describes how much my health information is used and shared. I may obtain a copy by contacting the Privacy Official or by visiting the web site at www.creativetherapeutics.com.

My signature below acknowledges that I have been provided with a copy of the notice of information practices.

_____
Patient Name

_____
Signature

_____
Date

Notice of Patient Information Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

LEGAL DUTY

Creative Therapeutics P.T., Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Creative Therapeutics P.T., Inc. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, *Creative Therapeutics, P.T., Inc.* may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Creative Therapeutics P.T., Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, *Creative Therapeutics, P.T., Inc.*'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

Creative Therapeutics P.T., Inc. may change its policy at any time. When changes made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specially authorized by you, when required by law or in emergency circumstances. *Creative Therapeutics P.T., Inc.* will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that *Creative Therapeutics P.T., Inc.* may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Practice Administrator at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on *Creative Therapeutics P.T., Inc.*'s health information practices or if you have a complaint, please contact the following person:

KATINKA YEPEZ, PRACTICE ADMINISTRATOR
2763 E. Shaw Ave., #102 Fresno, CA 93710
Telephone: 559-294-8112 FAX: 559-294-7805

CREATIVE THERAPEUTICS
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Women's Pelvic Pain Assessment

2763 E. Shaw Ave. #102 (559) 294-8112 (559) 294-7805

www.creativetherapeutics.com

Date: _____

Initial History and Physical Examination

This assessment form is intended to assist the clinician with the initial patient assessment and is not meant to be a diagnostic tool.

Patient Information

Name: _____ DOB: _____

Address: _____ City: _____ ZIP code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Referring Provider: _____ PC Provider: _____

Primary Insurance: _____

Insured's name and D.O.B.: _____

Secondary Insurance: _____

Have you had physical therapy this year? Yes___ No___ If Yes, how many visits this current year and when? _____

For what problem? _____

_____

Medical History

Please list any medical problems/diagnoses: (Use a separate paper if needed.)

_____

_____

_____

Allergies (medications, food, latex, etc.): _____

Have you had major accidents, such as a falls or a back injury? ☐ Yes ☐ No

Have you ever been treated for depression? ☐ Yes ☐ No Treatments: ☐ Medication ☐ Hospitalization ☐ Psychotherapy

Birth Control Method: ☐ Nothing ☐ Pill ☐ Vasectomy ☐ Vaginal Ring ☐ Depo Provera ☐ Condom
☐ IUD ☐ Hysterectomy ☐ Diaphragm ☐ Tubal Sterilization ☐ Other

Demographic Information:

Are you...? (Check all that apply):

☐ Married ☐ Single ☐ Committed Relationship ☐ Domestic Partner ☐ Same Sex Relationship

What type of work are you trained for? _____

What type of work are you doing? _____

Surgical History

Please list all surgical procedures you have had related to this pain:

Year	Procedure	Surgeon	Findings

Please list all other surgical procedures:

Year	Procedure

Medications

Please list all medications you are taking and the provider who prescribed them. (Use a separate paper if needed):

Medication/Dose	Provider	Does it help?
		O Yes O No O Currently taking
		O Yes O No O Currently taking
		O Yes O No O Currently taking
		O Yes O No O Currently taking
		O Yes O No O Currently taking
		O Yes O No O Currently taking
		O Yes O No O Currently taking

Gastrointestinal/Eating

Do you have nausea? ☐ No ☐ With pain ☐ Taking medication ☐ With Eating ☐ Other

Do you have vomiting? ☐ No ☐ With pain ☐ Taking medication ☐ With Eating ☐ Other

Have you ever had an eating disorder such as anorexia or bulimia? ☐ Yes ☐ No

Are you experiencing rectal bleeding or blood in your stool? ☐ Yes ☐ No

Do you have increased pain with bowel movements? ☐ Yes ☐ No

Change in frequency of bowel movement? ☐ Yes ☐ No

Change in appearance of stool or bowel movement? ☐ Yes ☐ No

Does your pain improve after completing a bowel movement? ☐ Yes ☐ No

Health Habits

How often do you exercise? ☐ Rarely ☐ 1-2 times weekly ☐ 3-5 times weekly ☐ Daily

What is your caffeine intake (number of cups per day, including coffee, teas, soft drinks, etc.)?

☐ 0 ☐ 1-3 ☐ 4-6 ☐ 6+

What is your water intake (number of cups per day.)?

☐ 0 ☐ 1-3 ☐ 4-6 ☐ 6+

Do you smoke? ☐ Yes ☐ No If "yes", for how many years? ____ Cigarettes per day? _____

DO you drink alcohol? ☐ Yes ☐ No Number of drinks per week_____

How would you describe your diet? (Check all that apply)

☐ Well balanced ☐ Vegan ☐ Vegetarian ☐ Fried Food ☐ Special Diet ☐ Other: _____

Obstetrical History

How many pregnancies have you had? _____

Resulting in (#): _____Full 9 Months _____Premature _____Miscarriage/Abortion _____Living Children

Were there any complications during pregnancy, labor, delivery, or post-partum?

☐ Episiotomy ☐ C-Section ☐ Vacuum ☐ Post-partum hemorrhaging

☐ Vaginal Laceration ☐ Forceps ☐ Medication for bleeding ☐ Other_____

Menstrual History

How old were you when your menstrual cycle started? _____

Are you still having menstrual periods? ☐ Yes ☐ No

Answer the following only if you are still having menstrual periods.

Periods are: ☐ Light ☐ Moderate ☐ Heavy ☐ Bleed through protection

How many days between your periods? _____

How many days of menstrual flow? _____

Date of first day or your last menstrual period_____

Do you have any pain with your periods? ☐ Yes ☐ No

Does the pain start the day your flow starts? ☐ Yes ☐ No Pain starts _____days before flow

Are your periods regular? ☐ Yes ☐ No

Do you pass clots in menstrual flow? ☐ Yes ☐ No

Information about your problem/pain

Please describe the issue that brings you to physical therapy (use a separate piece of paper, if needed):

_____

_____

_____

_____

What do you think is causing your problem/pain? _____

Is there an event that you associate with the onset of your problem/ pain? Yes No If so, what? _____

How long have you had this problem/ pain? _____years _____months

Urinary Symptoms

DO you experience any of the following?

Loss of urine with coughing, sneezing, or laughing?	☐ Yes ☐ No
Difficulty passing urine?	☐ Yes ☐ No
Frequent bladder infections?	☐ Yes ☐ No
Blood in the urine?	☐ Yes ☐ No
Still feeling full after urination?	☐ Yes ☐ No
Having to void within minutes of voiding?	☐ Yes ☐ No

Please circle the best answer that describes your bladder and bowel function and symptoms.

How many times do you go to the bathroom **during the day** (to void or empty your **bladder**)?	3-6	7-10	11-14	15-19	20 or more
How many times do you go to the bathroom **at night** (to void or empty your **bladder**)?	0	1	2	3	4 or more
How many times do you go to the bathroom **during the day (bowel movement)**?	0	1-2	3-4	5-6	6+
How many times do you go to the bathroom **at night (bowel movement)**?	0	1	2	3	4 or more
Are you sexually active?	Yes	No			
If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always	
Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, or perineum)?	Never	Occasionally	Usually	Always	
Do you have urgency after voiding?	Never	Occasionally	Usually	Always	
Do you have urgency after a bowel movement?	Never	Occasionally	Usually	Always	
If You have pain, is it usually?	Never	Mild	Moderate	Severe	
If you have urgency, is it usually	Never	Mild	Moderate	Severe	

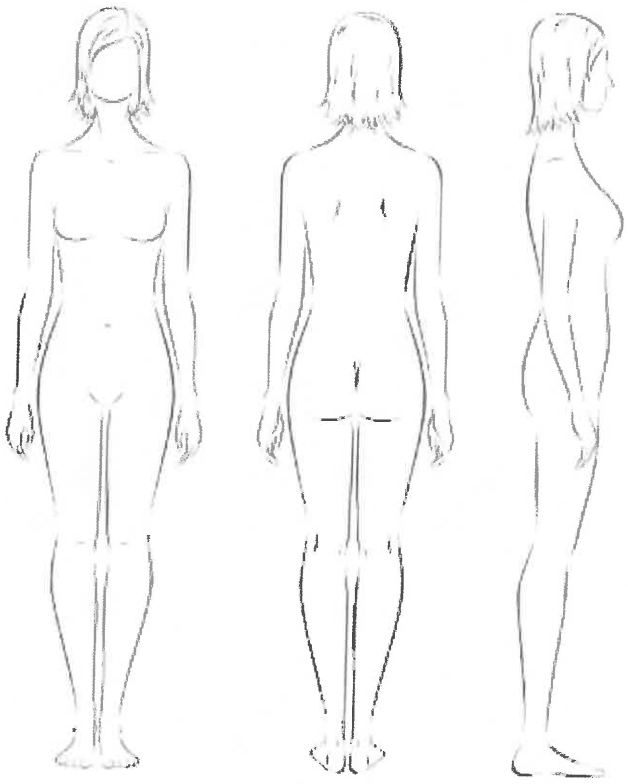
Pain only

For each of the pain symptoms please "bubble in" your level of pain over the last month using a 10-point scale:

0 – no pain 10 – The worst pain imaginable

How would you rate you pain?	0	1	2	3	4	5	6	7	8	9	10
Pain at ovulation	O	O	O	O	O	O	O	O	O	O	O
Pain just before period	O	O	O	O	O	O	O	O	O	O	O
Pain (not cramps) before period	O	O	O	O	O	O	O	O	O	O	O
Deep pain with intercourse	O	O	O	O	O	O	O	O	O	O	O
Pain in groin when lifting	O	O	O	O	O	O	O	O	O	O	O
Pelvic Pain Lasting hour/days after intercourse	O	O	O	O	O	O	O	O	O	O	O
Pain when bladder is full	O	O	O	O	O	O	O	O	O	O	O
Muscle/joint pain	O	O	O	O	O	O	O	O	O	O	O
Level of cramps with period	O	O	O	O	O	O	O	O	O	O	O
Pain after period is over	O	O	O	O	O	O	O	O	O	O	O
Burning vaginal pain after sex	O	O	O	O	O	O	O	O	O	O	O
Pain with urination	O	O	O	O	O	O	O	O	O	O	O
Backache	O	O	O	O	O	O	O	O	O	O	O
Migraine headache	O	O	O	O	O	O	O	O	O	O	O
Pain with sitting	O	O	O	O	O	O	O	O	O	O	O

Please Shade areas of pain and write a number from 1-10 at the site(s) of pain. (10 = the most severe pain imaginable)



Right Left Left Right

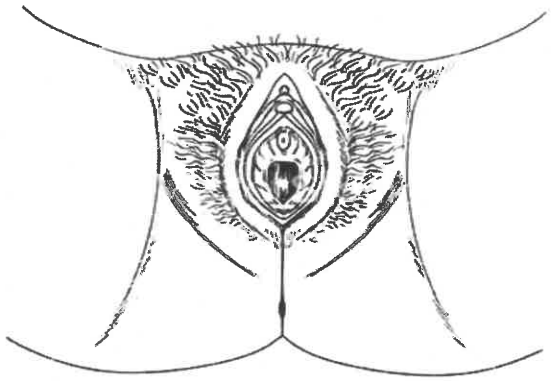
Vulvar/ Perineal Pain

(Pain outside and around the vagina and anus)

If you have vulvar pain, shade the painful areas and write the number 1-10 at the painful sites (10= most severe pain imaginable)

Is your pain relieved by sitting on a commode seat? ☐ Yes ☐ No

Right Left



The words below describe average pain. Place a check mark in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of pain in your pelvic area only.

What does your pain feel like?

Type	None (0)	Mild (1)	Moderate (2)	Severe (3)
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

Information about your problem/pain

What types of treatments / providers have you tried in the past for your problem/pain?

O Acupuncture
O Anesthesiologist
O Anti-seizure medication
O Antidepressants
O Biofeedback
O Botox Injection
O Contraceptive pills /patch /ring
O Danazol (Danocrine)
O Depo-Provera
O Gastroenterologist
O Gynecologist
O Family Practitioner
O Herbal Medicine
O Homeopathic medicine
O Lupron, Synarel, Zoladex
O Massage
O Meditation
O Narcotics
O Naturopathic medication
O Nerve Blocks
O Neurosurgeon
O Nonprescription medicines
O Nutrition/ Diet
O Physical Therapy
O Psychopathy
O Psychiatrist
O Rheumatologist
O Skin Magnets
O Surgery
O Tens unit
O Trigger point injections
O Urologist
O Other: _____

What physicians or health care providers have evaluated or treated you for your pelvic health issue?

Physician/Provider	Specialty	City, State, Phone

Coping Mechanisms

What helps your pain? ☐ Meditation ☐ Relaxation ☐ Laying down ☐ Music
☐ Massage ☐ Heating pad ☐ Hot bath ☐ Pain Medication
☐ Laxative/Enema ☐ Injection ☐ TENS Unit ☐ Bowel Movement
☐ Emptying Bladder ☐ Nothing ☐ Ice ☐ Other: _____

What makes your pain worse? ☐ Intercourse ☐ Orgasm ☐ Stress ☐ Full Meal ☐ Bowel Movement
☐ Full bladder ☐ Full bowel ☐ Urination ☐ Standing ☐ Walking ☐ Exercise
☐ Time of Day ☐ Weather ☐ Contact with clothing ☐ Coughing/ Sneezing
☐ Not related to anything ☐ Other_____

Of all the problems or stresses in your life, how does your pain compare in importance?
☐ Most important ☐ Just one of many problems

Sexual and Physical Abuse History

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted.

☐ Yes ☐ No If yes, what age (13 and younger) (14 and over)

Have you ever been the victim of physical/sexual abuse?

☐ Yes ☐ No If yes, what age (13 and younger) (14 and over)

Consent for Internal Pelvic Floor Examination

I, (print name) _____ give my consent for Sandra Bausman, PT, WCS, Nancy Larson, PT, WCS or Kimberley Voelz, PT, DPT to do a vaginal/rectal examination for the purpose of evaluation of my condition and therapeutic treatment.

1. The purpose, procedure, and risks of this procedure have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort, or unusual symptoms during the procedure.
4. I have the option of having a second person in the room during the procedure and ____ choose/____ refuse this option.

I have read this consent form and understand its terms, and I am signing it knowingly and voluntarily.

Patient Signature _____Date_____

PATIENT INFORMATION

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

D.O.B.: _____ SEX: MALE____ FEMALE____

HOME PHONE: _____ CELL: _____

WORK PHONE: _____ E-MAIL: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATION TO PATIENT: _____

REFERRING PHYSICIAN: _____

PRIMARY INSURANCE: _____

INSURED'S NAME AND D.O.B.: _____

SECONDARY INSURANCE: _____

Have you had physical therapy this year? Yes_____ No_____

If YES, How many times this current year and when? _____

MAIN ENTRANCE
2763 E. Shaw Ave Suite 102