PHYSICAL THERAPY
CHIROPRACTIC
ACUPUNCTURE
MASSAGE THERAPY

Pelvic Floor PT **New Patient Paperwork**

Name_____

Date _____

Patient Information

First Name_____ Middle Name_____ Last Name_____

Sex: Male Female Marital Status: Married Single Divorced DOB_____

Address: _____ _____ _____

City_____ State_____ Zip_____

Home #_____ Work #_____ Cell #_____

Email:_____ _____ Cell Provider_____

Emergency Contact_____ Relation_____ Phone_____

Spouse's Name_____ Parent Name (If patient is a minor)_____ _____

Employed: Full Part Unemployed Student:_____ School_____

Employer Name_____ Employer Address_____ _____

Occupation_____ Zip _____ _____

How did you hear about our office? Patient Referral Physician Referral Name_____

Insurance Information

Primary Ins_____ Phone #: _____ ID#_____

Group#_____

Claim Address: _____

City: _____ State: _____ Zip: _____

Subscriber Name_____ Subscriber DOB_____ Secondary ID_____

Secondary Ins_____ Secondary Phone #:_____ Secondary GRP_____

Secondary Address: _____

City: _____ State: _____ Zip_____

Subscriber Name_____ Subscriber DOB_____

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NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

		Yes	No
a.	Area between rectum and testicles (perineum)	❑1	❑0
b.	Testicles	❑1	❑0
c.	Tip of the penis (not related to urination)	❑1	❑0
d.	Below your waist, in your pubic or bladder area	❑1	❑0

2. In the last week, have you experienced:

		Yes	No
a.	Pain or burning during urination?	❑1	❑0
b.	Pain or discomfort during or after sexual climax (ejaculation)?	❑1	❑0

3. How often have you had pain or discomfort in any of these areas over the last week?

- ❑0 Never
- ❑1 Rarely
- ❑2 Sometimes
- ❑3 Often
- ❑4 Usually
- ❑5 Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

- ❑0 Not at all
- ❑1 Less than 1 time in 5
- ❑2 Less than half the time
- ❑3 About half the time
- ❑4 More than half the time
- ❑5 Almost always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- ❑0 Not at all
- ❑1 Less than 1 time in 5
- ❑2 Less than half the time
- ❑3 About half the time
- ❑4 More than half the time
- ❑5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

- ❑0 None
- ❑1 Only a little
- ❑2 Some
- ❑3 A lot

8. How much did you think about your symptoms, over the last week?

- ❑0 None
- ❑1 Only a little
- ❑2 Some
- ❑3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

- ❑0 Delighted
- ❑1 Pleased
- ❑2 Mostly satisfied
- ❑3 Mixed (about equally satisfied and dissatisfied)
- ❑4 Mostly dissatisfied
- ❑5 Unhappy
- ❑6 Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c,1d, 2a, 2b, 3, and 4 = _____

Urinary Symptoms: Total of items 5 and 6 = _____

Quality of Life Impact: Total of items 7, 8, and 9 = _____

Urogenital Distress Inventory (UDI-6 Short Form): UDI-6

1) Do you usually experience frequent urination? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

2) Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

3) Do you usually experience urine leakage related to coughing, sneezing, or laughing? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

4) Do you experience small amounts of urine leakage (that is, drops)? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

5) Do you experience difficulty emptying your bladder? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

6) Do you usually experience pain or discomfort in the lower abdomen or genital region? ☐ Yes ☐ No

   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

   If yes, then is your pain relieved after emptying your bladder? ☐ Yes ☐ No

No= 0, Not at all= 1, Somewhat= 2, Moderately= 3, Quite a bit= 4
Add all scores and multiply by 6 then multiply by 25 for the scale score
Missing items are dealt with by using the mean from the answered items only
Higher score = higher disability
Also see scoring of PFDI-20.

Uebersax JS, Wyman JF, Shumaker SA, McClish DK, Fantl AJ. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and the urogenital distress inventory. *Neurourol and Urodynam* 1995;14:131-139.

Grade A rating for symptoms of UI for women
Donavan J, et al Symptom and quality of life assessment. In Incontinence vol 1 Basics and Evaluation eds Abrams P, Cardozo L, Khoury S, Wein A. Health Publications Ltd Paris France 2005.

Name: _____ Date: _____

Pain Disability Index

In order to determine how effective your treatment is, we need to know how much pain is interfering in your normal activities. For the 7 areas listed below, please circle the number on the scale which describes the level of disability you have experienced in each area OVER THE PAST WEEK. A score of "0" means no disability at all, and a score of "10" indicates that all of the activities which you would normally do have been totally disrupted or prevented by your pain over the past week. Circle "0" if a category does not apply to you.

Family/Home Responsibilities: This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g. yard work, house cleaning) and errands or favors for other family members (e.g. driving the children to school.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Social Activity: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as housewife or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Self-Care: This category includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed).

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Life-Support Activity: This category refers to basic life-supporting behaviors such as eating and sleeping.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Total Score: _____