2917 Lake Shore Blvd, West.
Toronto, Ontario. M8V 1J3
647-748-2917 | PHYSIOINTHESIX.COM

All information will be held in strict confidence.

Last Name______________________________ First Name________________________________ Initial______

Date of Birth (*dd/mm/yyyy*) ____/____/_______ Occupation______________________________

Address____ City_________________ Postal Code_______________

Email____

Home Phone_________________________ Work Phone_________________________ Cell Phone _________________________

Direct Billing Information: Insurance Company____

Policy Holder Last Name_______________________________ Policy No.______________________ Policy

Holder First Name_______________________________ ID/Certificate No.______________________

For WSIB Claims Only: OHIP No. _________________________ WSIB Claim No.____________________

For Auto Insurance Claims Only: Auto Insurance Company____

Address___________________________________ Phone/Fax ____________________________

Claim No. _________________________________ Policy No._____________________________

Date of Accident (*dd/mm/yyyy*) ____/____/_______ Adjustor Name _________________________

Family Physician

Name_____________________________________

Address___________________________________

Phone_____________________________________

Fax ______________________________________

How did you hear about us?

Doctor____ Friend ____ Media____ Walk-In____

Insurance Company_____ Family Member_____ Other_____

Referral Source's Name (*Optional*)

____

Contact in case of Emergency

Name____________________________________ Relationship______________________________

Home Phone_____________________________ Work Phone______________________________

SERVICE	TOTAL FEE
Physiotherapy Assessment	**$ 110.00**
Physiotherapy Treatment per unit	**$70.00**
Physiotherapy Re-assessment ***greater than six months since last assessment or new complaint**	**$ 110.00**
Pelvic Health Assessment (1 hour)	**$140.00**
Pelvic Health Treatment (30 min/45 min)	**$80.00/$100.00**

N.B. Fees are subject to change.

****Our cancellation policy requires 24 hours notice or you will be charged 50% of the fee****

This signed form and photocopies of this signed form will serve as authorization to the Physio In The Six Inc. Clinic to obtain/release medical information pertaining to myself from/to my family physician and to other Physio In The Six Inc. Clinic practitioners. It also serves as an agreement to provide payment to Physio In The Six Inc. Clinic, at the time of each visit, and later claim through any extended health benefits plan, as appropriate. The undersigned has read and understands the cancellation policy.

Signature_____________________________________ **Date (*dd/mm/yyyy*)** ____/____/______

Patient name: ________________________________ DOB: ______________ Date: ______________

Female Symptom Monitor

Occupation ____

Presenting problems ____

____

____

When did this start? ____

Please fill out each section that is relevant to your problem

Gynecological History

What age did your period start? ________________________ Is your cycle regular? ☐☐ No ☐☐ Yes

How long is your cycle? ______________ Do you suffer from PMS? ☐☐ Yes ☐☐ No Is your bleeding heavy? ☐☐ Yes ☐☐ No

Do you have pain with your period? ☐☐ No ☐☐ Yes If yes, when? ________________________________

Do you use tampons? ☐☐ No ☐☐ Yes Do you have pain with insertion of a tampon? ☐☐ No ☐☐ Yes

Do you have excessive discharge? ☐☐ Yes ☐☐ No Sexually active? ☐☐ No ☐☐ Yes

Birth control? ☐☐ Yes ☐☐ No Type: ________________ Pain with intercourse? ☐☐ Yes ☐☐ No

# of pregnancies _______ # of live births ______________ Wt. heaviest baby ______ lbs ______ oz

Length pushing stage _______ hours # of C---sections ________ # of vaginal deliveries ________

Did you have an epidural? ☐☐ Yes ☐☐ No Did you have a vacuum---assisted delivery? ☐☐ Yes ☐☐ No

Forceps? ☐☐ Yes ☐☐ No Episiotomies? ☐☐ Yes ☐☐ No Tears? ☐☐ Yes ☐☐ No

During my labour(s) and delivery, I felt supported and cared for:
☐☐ All or most of the time ☐☐ Some of the time ☐☐ A little bit ☐☐ Not at all

Were there times during labour and delivery that you were (or thought you were) in danger of death or injury? ☐☐Yes ☐☐No

Were there times when the baby was or seemed to be in danger during labour and delivery? ☐☐Yes ☐☐No

Do you suffer/have you suffered from post---partum depression? ☐☐Yes ☐☐No

Have you gone through menopause? ☐☐ Yes ☐☐ No If so, when? ____________ Do you suffer from vaginal dryness? ☐☐Yes ☐☐No

Hormone replacement therapy ☐☐ Yes ☐☐ No If yes, what? ______________________________

Do you use lubrication? ☐☐ Yes ☐☐ No Sometimes What type: ______________________

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Patient name: ________________________________ DOB: ______________ Date: ______________

Do you have feelings of heaviness/pressure in your vagina?	☐☐ Yes ☐☐ No	Have you ever been told you have a prolapse?	☐☐ Yes ☐☐ No

Have you had any of the following medical procedures? If so, please provide approximate date:

Procedure	Date	Procedure	Date	Procedure	Date
Appendectomy	________________	Bartholin Cyst	________________	Bowel resection	________________
Laparoscopy	________________	Cystoscopy	________________	Colostomy	________________
TVT---TVT(O)	________________	Gallbladder removal	________________	Hemorrhoid surgery	________________
Mesh procedure	________________	Prolapse/Vaginal repair	________________	Hysterectomy	________________

Other ________________________________

Bladder Symptoms

Did you have problems with your bladder during childhood?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Do you have leakage associated with sneezing, coughing, running and/or laughing?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Do you have leakage during intercourse?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Do you feel really strong sensations prior to voiding but don't leak?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Does your leakage occur after having a strong urge that feels uncontrollable?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Do you have pain when your bladder fills?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Does your pain improve when you void?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Do you have pain when you void?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Do you have to strain in order to empty your bladder?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Do you have difficulty starting your urine steam?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Do you have dribbling after you get up from the toilet?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Do you sit on the toilet?	☐☐ No	☐☐ Yes	☐☐ Sometimes
Do you have incomplete emptying when you void and feel like you have to go again soon?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Do your bladder problems cause you to leak at night?	☐☐ Yes	☐☐ No	☐☐ Sometimes
Does your incontinence fluctuate with your cycle?	☐☐ Yes	☐☐ No	☐☐ Sometimes

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Patient name: ______________________________ DOB: ______________ Date: ______________

Does your incontinence require you to wear pads? ☐☐ Yes ☐☐ No ☐☐ Sometimes

If you answered yes or sometimes, how often? __________________

Do you void during the day more than the average person (5---7x/day)? ☐☐ Yes ☐☐ No ☐☐ Sometimes

If you answered yes or sometimes, how often? __________________

Do you need to get up at night to void? ☐☐ Yes ☐☐ No ☐☐ Sometimes

If you answered yes or sometimes, how many times? _____________

Fluid intake in 24 hours

________ cups of water/day # ________ cups of coffee/day # ________ cups of tea/day

________ cups of other fluids/day # ________ alcoholic drinks/day

Digestion & Bowel Function

What is the frequency of your bowel movements?

____

Question			
Do you regularly feel the urge to move your bowels?	☐☐ Never	☐☐ Seldom	☐☐ Always
Do you have constipation?	☐☐ Always	☐☐ Seldom	☐☐ Never
Do you strain to have a bowel movement?	☐☐ Always	☐☐ Seldom	☐☐ Never
Do you have loose stools/diarrhea?	☐☐ Always	☐☐ Seldom	☐☐ Never
Do you have bowel urgency that is difficult to control?	☐☐ Always	☐☐ Seldom	☐☐ Never
Do you lose control of your bowels?	☐☐ Always	☐☐ Seldom	☐☐ Never
Do you have incomplete emptying?	☐☐ Always	☐☐ Seldom	☐☐ Never
Do you have pain <u>with</u> a bowel movement?	☐☐ Always	☐☐ Seldom	☐☐ Never
Do you have pain <u>after</u> a bowel movement?	☐☐ Always	☐☐ Seldom	☐☐ Never
Does it take longer than 5 minutes to have a bowel movement?	☐☐ Always	☐☐ Seldom	☐☐ Never
Do you have bloating? (Increased pressure in abdomen)	☐☐ Always	☐☐ Seldom	☐☐ Never
Do you experience a physical change in abdominal girth when your bowels are full (distension)?	☐☐ Always	☐☐ Seldom	☐☐ Never

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In your opinion, is your fibre intake ☐☐ Too low ☐☐ Adequate ☐☐ Too high

Do you regularly use ☐☐ Laxatives ☐☐ Stool softeners ☐☐ Natural products ☐☐ Enemas

Have you ever been diagnosed with/think you have:

Irritable bowel syndrome When? ______________________ Who? ______________________

Ulcerative colitis When? ______________________ Who? ______________________

Crohn's Disease When? ______________________ Who? ______________________

Celiac Disease When? ______________________ Who? ______________________

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Patient name: ______________________________ DOB: _____________ Date: _____________

Do you have any food allergies or sensitivities? ____

____

____

Medical History

Urinary tract infections ☐☐ Yes ☐☐ No How often? ______________________________________

Antibiotics recently? ☐☐ Yes ☐☐ No Last UTI? ______________________________________

Probiotics? ☐☐ No ☐☐ Yes Cranberry supplementation? ☐☐ No ☐☐ Yes

Smoking ☐☐ Yes ☐☐ No # ______ packs/day Chronic cough ☐☐ Yes ☐☐ No

Yeast infections ☐☐ Yes ☐☐ No How often? ______________________________________

Last infection __________________________ Treatment ________________________________

Do you get blood in your urine? ☐☐ Yes ☐☐ No

Allergies (including latex): ____

Do you exercise? ☐☐ No ☐☐ Yes Type: __________________________ Frequency: _________

Low back problems ☐☐ Yes ☐☐ No Chronic? ☐☐ Yes ☐☐ No

Mid back problems ☐☐ Yes ☐☐ No Chronic? ☐☐ Yes ☐☐ No

Neck problems ☐☐ Yes ☐☐ No Chronic? ☐☐ Yes ☐☐ No

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Have you ever been treated for depression? ☐☐ Yes ☐☐ No What treatment? ________________________________

Is/was treatment effective? ☐☐ No ☐☐ Yes

Have you ever been treated for anxiety? ☐☐ Yes ☐☐ No What treatment? ________________________________

Is/was treatment effective? ☐☐ No ☐☐ Yes

On a scale from 1---10, please circle and rate how much this problem bothers you

1 2 3 4 5 6 7 8 9 10

On a scale from 1---10, please circle and rate how motivated you are to correct this problem

1 2 3 4 5 6 7 8 9 10

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Patient name: ______________________________ DOB: _____________ Date: _____________

DASS Questionnaire

Please read each statement and circle a number, o, 1, 2, or 3, which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

S = _____ A = _____ D = _____

0 = It did not apply to me at all
1 = Applied to me to some degree or some of the time
2 = Applied to me a considerable degree, or a good part of the time
3 = Applied to me very much, or most of the time

I find it hard to wind down………………………………………………………………………… S 0 1 2 3

I was aware of dryness of my mouth………………………………………………………………. A 0 1 2 3

I could not seem to experience any feeling at all……………………………………………… D 0 1 2 3

I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness

in the absence of physical exertion……………………………………………………………… A 0 1 2 3

I found it difficult to work up the initiative to do things…………………………………… D 0 1 2 3

I tended to over---react to situations……………………………………………………………. S 0 1 2 3

I experienced trembling (e.g. hands)…………………………………………………………… A 0 1 2 3

I felt that I was using a lot of nervous energy………………………………………………… S 0 1 2 3

I was worried about situations in which I might panic and make a fool of myself….. A 0 1 2 3

I felt that I had nothing to look forward to…………………………………………………… D 0 1 2 3

I found myself getting agitated………………………………………………………………… S 0 1 2 3

I found it difficult to relax………………………………………………………………………… S 0 1 2 3

I felt down---hearted and blue…………………………………………………………………… D 0 1 2 3

I was intolerant of anything that kept me from getting on with what I was doing…. S 0 1 2 3

I felt I was close to panic………………………………………………………………………… A 0 1 2 3

I was unable to become enthusiastic about anything……………………………………… D 0 1 2 3

I felt I was not much of a person………………………………………………………………… D 0 1 2 3

I felt that I was rather touchy…………………………………………………………………… S 0 1 2 3

I was aware of the action of my heart in the absence of physical exertion (e.g.

sense of heart rate increase, heart missing a beat)………………………………………… A 0 1 2 3

I felt scared without any good reason…………………………………………………………… A 0 1 2 3

I felt that life was meaningless………………………………………………………………… D 0 1 2 3

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Physio In The Six Inc.

PELVIC HEALTH PHYSIOTHERAPY CONSENT TO TREATMENT

I hereby consent to the assessment and treatment performed by the Registered Physiotherapist named below.

I understand that treatment may include treatments for therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purposes.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vaginal 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.

I understand that I may rescind or amend this consent in writing.

I further understand that the clinical, psychological and any other information which is gathered during the course of my treatment is confidential, but may be shared with my insuring agents, third party payers and/or physician(s) upon request.

I have read the above consent, and I have had the opportunity to ask questions about its content. This consent will cover the physiotherapy assessment and entire course of treatment.

____
Patient's Name (*Please print*)

____
Physiotherapist's Name (*Please print*)

Date of Birth: (*dd/mm/yyyy*) ____/____/________

____
Signature of Patient

____
Date Signed

The Health Information Custodian of this chart is Physio In The Six Inc.

Physio In The Six Inc.
2917 Lake Shore Blvd West
Toronto, ON
M8V 1J3