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:**_____

Persistent Pelvic Pain In Women

Please describe your pain problem(s) _____

_____

_____

_____

_____

Is there an event that you associate with the onset of your pain? □ Yes □ No

If so, what?_____

How long have you had pain? _____ years _____ months

What have you been told is causing your pain?_____

What do you think is causing your pain? _____

Has the pain spread from its original problem? □ Yes □ No

Social History

The Adverse Childhood Experience (ACE) study (1997) demonstrated with >17,000 participants that traumatic experiences during childhood have a direct impact on the health of adults, especially if the have not been given the opportunity to talk about these events in a safe and empathetic environment. In that regard, your social history is very important and confidential.

Where were you born? _____

How any siblings do you have? _____

How would you describe your childhood? Average / Happy / Sad / Other:

Where you physically/emotionally abuse as a child? □ Yes □ No

Have you been touched sexually when you did not want it? □ Yes □ No

Have you ever had sex against your will? □ Yes □ No

Has anyone in your family been killed? □ Yes □ No

Has anyone in your family had a nervous breakdown? □ Yes □ No

Has anyone in your family committed suicide? □ Yes □ No

Has anyone in your family been a drug abuse user or alcoholic? □ Yes □ No

Do you abuse drugs or alcohol? □ Yes □ No

Have you ever fought in a war? □ Yes □ No

Patient Name: _____ **DOB:**_____ **Date:**_____

Have you ever lived in a war zone? □ Yes □ No

Are you: □ Married □ Widowed □ Separated □ Single □ Remarried

□ Divorced □ Committed relationship

Who lives in your home? _____

Who are the people you talk to when you are in pain? _____

How do you cope with stress? _____

How does your partner cope with your pain/stress? _____

How does your pain affect your family? _____

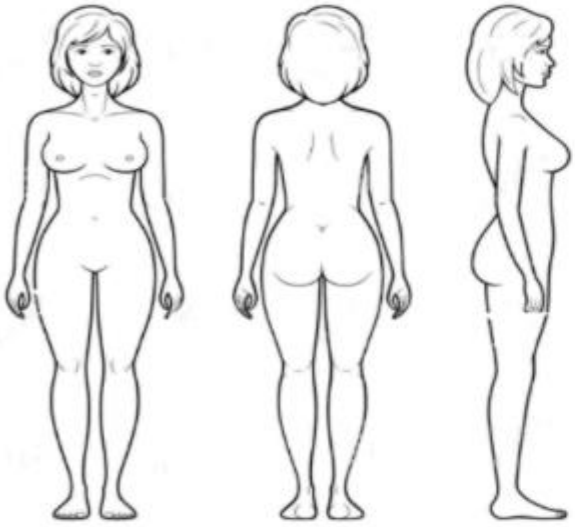
What type of work are you trained for? _____

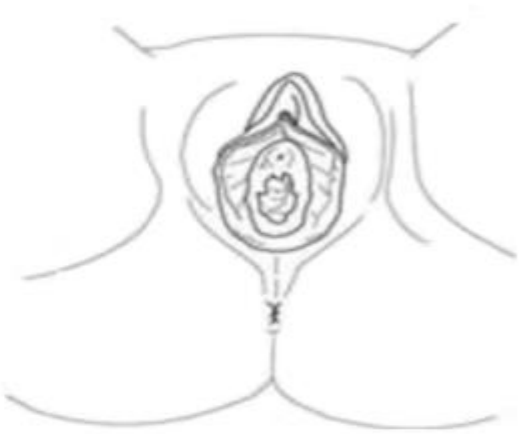
What type of work are you doing? _____

Do you like your job? _____

Have you ever been for counseling? _____

Please mark on the diagrams below where your pain is located





Some of these questions may not be applicable or uncomfortable; please answer all appropriate questions

Are you physically intimate with your partner without penetration?	□ Yes	□ No	□ Sometimes
Do you have pain with penetration?	□ Yes	□ No	□ Sometimes
Do you have pain at the vaginal opening?	□ Yes	□ No	□ Sometimes
Do you have pain with thrusting?	□ Yes	□ No	□ Sometimes
Are you able to orgasm?	□ Yes	□ No	□ Sometimes
Do you have pain with orgasm?	□ Yes	□ No	□ Sometimes

Patient Name: _____ **DOB:**_____ **Date:**_____

Do you have pain after orgasm? □ Yes □ No □ Sometimes

Do you have clitoral pain? □ Yes □ No □ Sometimes

If you are unable to have intercourse with penetration, can you orgasm with clitoral stimulation? □ Yes □ No □ Sometimes

Do you participate in anal sex? □ Yes □ No □ Sometimes

If yes, is anal sex painful? □ Yes □ No □ Sometimes

Does your partner have sexual dysfunction? □ Yes □ No □ Sometimes

If yes, what type? _____

How is your libido? □ Normal □ Increased □ Decreased □ Non---existent

Do you regularly self-pleasure? □ Yes □ No □ Sometimes

Have you ever talked to a professional about sexual function? □ Yes □ No

Any further comments _____

What makes your pain worse?

□ Intercourse □ Orgasm □ Stress □ Full meal □ Bowel movement
□ Full bladder □ Urination □ Standing □ Walking □ Exercise
□ Time of day □ Sitting □ Contact with clothing □ Coughing/sneezing □ Weather
□ Not related to anything □ Other: _____

What helps soothe your pain?

□ Meditation □ Relaxation □ Lying down □ Music □ Massage
□ Ice □ Hot bath □ Heating pad □ Pain medication □ Laxatives/enem
□ Injection □ TENS unit □ Bowel movement □ Emptying bladder □ Nothing
□ Other: _____

Have you been diagnosed by a doctor with any of the following conditions?
Please check the box to the right for each diagnosis and write the year of diagnosis

	Yes	No	Date of Diagnosis	Physician/Provider
Restless leg syndrome	□	□		
Chronic fatigue syndrome	□	□		
Fibromyalgia	□	□		
Temporomandibular joint disorder (TMJ)	□	□		
Migraine or tension headaches	□	□		
Irritable bowel syndrome	□	□		
Multiple chemical sensitivities	□	□		
Neck injury (including whiplash)	□	□		
Anxiety or panic attacks	□	□		
Depression	□	□		

Patient Name: _____ **DOB:**_____ **Date:**_____

What treatment has your physician or health care provider provided?	
Condition	Treatment provided

Please list the medication you are currently taking (including vitamins and supplements)				
Medication/does	Provider			
		□ Yes	□ No	□ Currently taking
		□ Yes	□ No	□ Currently taking
		□ Yes	□ No	□ Currently taking
		□ Yes	□ No	□ Currently taking
		□ Yes	□ No	□ Currently taking
		□ Yes	□ No	□ Currently taking

In the past, have you taken any of the following supplements for this problem?

			Dosage
Vitamin D	□ No	□ Yes	_____
Magnesium	□ No	□ Yes	_____
Omega 3	□ No	□ Yes	_____
Cranberry juice/extract	□ No	□ Yes	_____

In the past, what lotions/creams have you used for this problem?

_____

_____

_____

Patient Name: _____ DOB:_____ Date:_____

Sleep Hygiene

Does it usually take you longer than 30 minutes to fall asleep?	□ Yes	□ No
Do you wake up more than twice a night?	□ Yes	□ No
Do you regularly drink coffee, tea, caffeinated pop or alcoholic drinks?	□ Yes	□ No
Do you feel that you are currently under significant stress?	□ Yes	□ No
Do you feel stress/anxiety contributes to your sleeping difficulties?	□ Yes	□ No
Do you feel that you are sensitive to noises and/or that noises wake you up?	□ Yes	□ No
Do you have sources of light in your bedroom at nights?	□ Yes	□ No
Does your sleeping partner keep you awake?	□ Yes	□ No
Do you feel that the air in your bedroom too hot, cold or unclean?	□ Yes	□ No
Do you feel that your mattress or your pillow is uncomfortable or >10 years old?	□ Yes	□ No
Do you sleep on your stomach?	□ Yes	□ No
Do you have "creeping, crawling or tingling" feelings in your legs?	□ Yes	□ No
Do you think you snore loudly, gasp or stop breathing during sleep?	□ Yes	□ No
Do you take narcotics for pain?	□ Yes	□ No

Patient Name: _____ **DOB:**_____ **Date:**_____

Central Sensitization Inventory: Part A

Please circle the best response to the right of each statement

I feel un-refreshed when I wake up in the morning.	Never	Rarely	Sometimes	Often	Always
My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always
I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always
I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always
I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always
I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always
I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always
I have headaches.	Never	Rarely	Sometimes	Often	Always
I feel discomfort in my bladder and/or burning when I urinate.	Never	Rarely	Sometimes	Often	Always
I do not sleep well.	Never	Rarely	Sometimes	Often	Always
I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always
I have skin problems such as dryness, itchiness or rashes.	Never	Rarely	Sometimes	Often	Always
Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always
I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always
I have low energy.	Never	Rarely	Sometimes	Often	Always
I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always
I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always
Certain smells, such as perfumes, make me feel and nauseated.	Never	Rarely	Sometimes	Often	Always dizzy
I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always
My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always
I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always
I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always
I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always

TOTAL _____

Patient Name: _____ DOB:_____ Date:_____

PCS Questionnaire

(Reference: on Quartana et al. Pain Catastrophizing: A ritical review. Expert Rev Neurother. 2009 May; 9(5):745--758)

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are 13 statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you experience pain.

0 = not at all 1 = to a slight degree 2 = to a moderate degree 3 = to a great degree 4 = all the time

When I'm in pain.....

(H) _____ I worry all the time about whether the pain will end

(H) _____ I feel I can't go on

(H) _____ It's terrible and I think it's never going to get any better

(H) _____ It's awful and I feel that it overwhelms me

(H) _____ I feel I can't stand it anymore

(M) _____ I become afraid that the pain will get worse

(M) _____ I keep thinking of other painful events

(R) _____ I anxiously want the pain to go away

(R) _____ I can't seem to keep it out of my mind

(R) _____ I keep thinking about how much it hurts

(R) _____ I keep thinking about how badly I want the pain to stop

(H) _____ There's nothing I can do to reduce the intensity of my pain

(M) _____ I wonder whether something serious will happen

TOTAL: _____

Patient Name: _____ DOB:_____ Date:_____

PANAS

(Reference: Watson, D., Clark L. A., & Tellegan, A. (1988). Development and validation of brief measures of the PANAS scales Journal of Personality and Social Psychology, 54(6),1063–1070.)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then list the number from the scale below next to each word. Indicate to what extent you feel this way right now, that is, at the present moment *OR* indicate the extent you have felt this way over the past week. Please circle if you used this measure for the present moment or over the past week.

1	2	3	4	5
Very slightly or not at all	**A little**	**Moderately**	**Quite a bit**	**Extremely**

_____ Interested
_____ Distressed
_____ Excited
_____ Upset
_____ Strong
_____ Guilty
_____ Scared
_____ Hostile
_____ Enthusiastic
_____ Proud

_____ Irritable
_____ Alert
_____ Ashamed
_____ Inspired
_____ Nervous
_____ Determined
_____ Attentive
_____ Jittery
_____ Active
_____ Afraid

Patient Name: _____ **DOB:**_____ **Date:**_____

Hormone Checklist

(Reference: Lorna VanderHaeghe; A Smart Woman's Guide to Hormones)

Please check all symptoms that apply (they will repeat themselves

Excess Progesterone:

□ Breast swelling and pain
□ Depression or low mood
□ Excess facial hair
□ Feeling tired, drowsiness
□ Hyperinsulinemia
□ Low libido
□ Oily skin
□ Brown spots on skin

Excess Estrogen:

□ Acne
□ Anemia
□ Asthma symptoms worsening
□ Depression
□ Uterine fibroids, fibrocystic breasts, ovarian cysts, PCOS, breast cancer, endometriosis
□ Fatigue
□ Fluid retention
□ Gallstones
□ Irritability
□ Loss of sex drive
□ Memory loss
□ Period problems
□ PMS – irritability, moodiness
□ Raging hot flashes and night sweats
□ Weight gain

Excess Testosterone:

□ Acne, oily skin
□ Facial hair growth
□ Hair loss
□ High DHEA (hormone blood work)
□ Ovarian cysts
□ Resistance to insulin
□ Weight gain

Low Progesterone:

□ Anxiety
□ Difficulty handling stress
□ Elevated cortisol levels
□ Uterine fibroids, fibrocystic breasts, ovarian cysts, PCOS, breast cancer, endometriosis
□ Headaches
□ Heavy periods
□ Low bone density
□ Multiple miscarriages
□ Water retention
□ Weight gain in abdomen
□ Insomnia

Low Estrogen:

□ Brain fog
□ Painful intercourse
□ Recurring urinary tract infections
□ Urinary incontinence
□ Vaginal dryness
□ Thinning of the vaginal wall
□ Hot flashes
□ Night sweats

Low Testosterone:

□ Fatigue
□ High cortisol
□ Loss of strength and stamina
□ Low DHEA (hormone blood work)
□ Low or no sex drive
□ Memory decline
□ Muscle wasting and weakness
□ Osteopenia
□ Osteoporosis
□ Sleep problems
□ Vaginal dryness

Patient Name: _____ **DOB:**_____ **Date:**_____

Overactive Thyroid:

□ Breathlessness
□ Fatigue
□ Hair loss
□ Heart palpitations
□ Heat intolerance
□ Increased frequency of bowel movements
□ Insomnia
□ Light or absent menstrual periods
□ Muscle weakness
□ Nervousness
□ Star gazing (bulging eyes)
□ Trembling hands
□ Warm, moist skin
□ Weight loss
□ Goiter (swelling of front of neck)

Low Thyroid:

□ A metallic taste in mouth
□ Anemia
□ Anxiety nervousness
□ Chronic fatigue, weakness, lethargy
□ Cold hands and feet, cold intolerance
□ Constipation
□ Cracking in the heels and skin
□ Depression and irritability
□ Doughy, soft abdomen
□ Dry, coarse skin, hair or both
□ Edema (swelling of the eyelids and face)
□ Elevated cholesterol levels
□ Unable to take a deep breath
□ Goiter (swelling of the front of the neck)
□ Hair loss
□ Headaches, dizziness
□ Heart palpitations
□ High TSH (over 2.0 blood work)
□ Uterine fibroids, fibrocystic breasts, ovarian cysts, PCOS, Breast cancer, endometriosis
□ Impaired memory
□ Infertility and/or recurring miscarriages
□ Insomnia
□ Low basal temperature
□ Low progesterone to estrogen ratio
□ Low T3, T4, T7 (blood work)
□ Night sweats
□ Poor concentration
□ Poor vision
□ Presence of thyroid antibodies
□ Racing thoughts
□ Severe menopause symptom (years)
□ Shortness of breath
□ Slow pulse
□ Slower metabolism, weight gain
□ Sudden change in personality

Excess Cortisol

□ Hair loss
□ High blood pressure
□ High insulin
□ Insulin resistance (diabetes)
□ Irritability, anxiety
□ Low DHEA (hormone blood work)
□ Low progesterone levels
□ Low drive
□ Low thyroid
□ Mood and depression
□ Osteoporosis
□ Poor immune function (sick all the time)
□ Weight gain
□ “wired but tired” feeling

Patient Name: _____ **DOB:**_____ **Date:**_____

Adrenal Stress:

□ Alcohol intolerance
□ Asthma/bronchitis
□ Blurred vision
□ Cold extremities
□ Cravings for stimulants, salt, sugar
□ Cravings for junk food, coffee, caffeine
□ Depression
□ Digestive problems
□ Dizziness upon rising
□ Swelling of feet and hands
□ Environmental sensitivities
□ Excessive perspiration
□ Excessive urination
□ Eyes light sensitive
□ Food allergies
□ Headaches
□ Heart palpitations
□ High cortisol
□ Hypoglycemia
□ Increase/loss of skin pigment
□ Endometriosis
□ Inflammation and joint/muscle pain
□ Bursitis
□ Insomnia
□ Irritability
□ Knee problems
□ Low back pain
□ Low energy
□ Excessive fatigue
□ Low thyroid
□ Muscle twitches
□ Nervousness/anxiety
□ Poor concentration
□ Post-exertional fatigue
□ Recurring infections
□ Shortness of breath
□ Tired feet
□ Ulcers

Menopause:

□ 45 or older
□ Have not had a period for 12+ months
□ No desire for sex
□ Feeling anxious, irritable and tired
□ Weight gain with no diet changes
□ Hot flashes and/or night sweats
□ Painful intercourse
□ Leaking urine
□ Insomnia
□ Memory problems/brain fog
□ Skin is excessively dry and wrinkled
□ Vaginal dryness

Peri- Menopause:

□ +35 years old
□ Reduced libido
□ Endometriosis
□ Fibroid breast cysts
□ Gained lbs. quickly, bloated abdomen
□ Headaches
□ Heavy periods, clotting for longer periods
□ Hot flashes and night sweats
□ Insomnia
□ Forgetfulness
□ PMS symptoms (period, irritability)
□ Skin outbreaks/acne
□ Infections
□ Thinning hair
□ Uterine fibroids

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