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:**________________

<u>Male Symptom Monitor</u>

Occupation ____

Presenting problems ____

____

____

When did this start?____

Please fill out each section that is relevant to your problem

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

Appendectomy	______________	Hernia repair	______________	Vasectomy	__________________
Hemorrhoid banding	______________	Prostatectomy	______________	Cystoscopy	__________________
Urodynamics	______________	Gallbladder removal	______________	Bowel resection	__________________
Colostomy	______________	Other	______________		

Bladder Symptoms

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 stream?	□ Yes	□ No	□ Sometimes
Do you have dribbling after you get up from the toilet?	□ Yes	□ No	□ Sometimes
Do you stand to void?	□ Yes	□ No	□ Sometimes
Do you have incomplete emptying when you void and feel like you have to go again soon?	□ Yes	□ No	□ Sometimes

Patient Name: ________________________ **DOB:**_____________________ **Date:**________________

Do your bladder problems cause you to leak at night? □ Yes □ No □ Sometimes

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 ____

Do you feel the urge to move your bowels?	□ Always	□ Seldom	□ Never
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 with a bowel movement?	□ Always	□ Seldom	□ Never
Do you have pain after 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

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

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

Pelvic Health Solutions

Patient Name: _________________________ **DOB:**______________________ **Date:**_________________

Have you ever been diagnosed with/think you have:

	Date of Diagnosis	Physician/ Provider
Irritable bowel syndrome		
Ulcerative colitis		
Crohn's Disease		
Celiac Disease		

Do you have any food allergies or sensitivities? ____

____

____

Medical History

Urinary tract infections □ Yes □ No How often? ____________________________________

Antibiotics recently? □ Yes □ No Last UTI? ______________________________________

Probiotics? □ Yes □ No Cranberry supplementation? □ Yes □ No

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

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

Allergies (including latex): ____

Do you exercise? □ Yes □ No 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

Have you ever been treated for depression? □ Yes □ No What treatment?__________________

Is/was treatment effective? □ Yes □ No

Have you ever been treated for anxiety? □ Yes □ No What treatment? ____________________

Is/was treatment effective? □ Yes □ No

PHYSIO IN THE SIX
Pelvic Health Solutions

Patient Name: ________________________ **DOB:**_____________________ **Date:**________________

Sexual history

Last PSA score: __________ When? _____________ Last digital rectal exam?__________________

Does your prostate get painful/irritated? □ Yes □ No

Has your prostate fluid been expressed and tested? □ Yes □ No

Do you have painful erections? □ Yes □ No

Can you achieve a satisfactory erection? □ Yes □ No

Do you have premature ejaculation? □ Yes □ No

Do you have pain during intercourse? □ Yes □ No When? ______________________

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

PHYSIO IN THE SIX

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

Pelvic Health Solutions

Patient Name: ________________________ DOB:_____________________ Date:________________

DASS Questionnaire

Please read each statement and circle a number, 0, 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

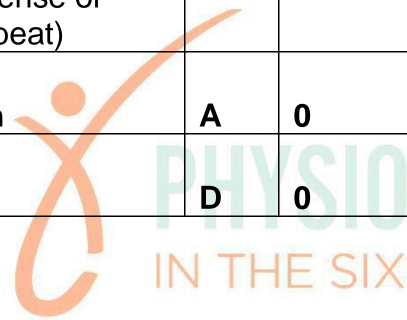
3 = Applied to me very much, or most of the time

PHYSIO IN THE SIX

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 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 overreact to situations	**S**	**0**	**1**	**2**	**3**
I experience 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**

Pelvic Health Solutions

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**



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

Pelvic Health Solutions