GLENWOOD SPORT & SPINE

DATE: _____

NAME: _____ Male / Female DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____
POSTAL CODE: _____ PHONE #: (h) _____
(w) _____
E-mail address: _____ (c) _____
(optional - for clinic communications)

Medical Doctor: _____ Health Care #: _____

How did you hear of our clinic?
__ from another patient: _____ (name)
__ google (internet) search
__ from my medical doctor
__ walked/drove by
__ other: _____

Marital Status: _____ Occupation: _____
Work / Private Health Insurance: _____
Emergency Contact: _____ Phone Number: _____

Is the reason you came to this office related to a –

A) ***RECENT*** Motor Vehicle Accident?	YES	NO
B) ***CURRENT*** Work-related injury? (WCB)	YES	NO

CHIROPRACTIC:	
Regular Treatment	$75
Re-Assessment	$85
Age 75+	bill insurance only
Assessment	$100

SHOCKWAVE THERAPY:	$90
CUSTOM ORTHOTICS:	$500
COMPRESSION STOCKINGS:	$150-$200

PHYSIOTHERAPY:	
Regular Treatment	$100
Extended Treatment	$150
Assessment	$150
Pelvic Floor Treatment	$135
Pelvic Ext Treatment	$175
Pelvic Floor Assessment	$175

MASSAGE:	
30 minutes	$65
45 minutes	$90
60 minutes	$110
60 minutes HOT STONE	$130
90 minutes	$150
90 minutes HOT STONE	$170

ACUPUNCTURE:	
Acu/IMS 30 min	$100
Acu/IMS 60 min	$130
Cupping & Tuina 30 min	$100
Cupping & Tuina 60 min	$130
Age 75+	bill insurance only
Assessment	$130

PSYCHOTHERAPY:	
Regular Session	$155
Couples Session	$155
Family Session	$225

Unless prior arrangements have been made, services must be paid for at the time they are provided. Fees are subject to change.
CANCELLATION NOTICE – 8 hr. notice is required for ALL appointments, NO SHOWS will be charged the regular fee.
Acceptance of this form gives Glenwood Sport & Spine consent to obtain insurance coverage information on your behalf.

Pelvic Physiotherapy Initial Intake Form

The information you are about to provide is for your benefit and protection.
It is for the private use of this office (unless you sign a release form)
to aid your Physiotherapist in gaining a better understanding of your condition.

Name: _____ Date: _____

Presenting Problems

What are your presenting problems?

_____

When did this start? _____

General Questions

What are some hobbies/ activities you do on a regular basis? _____

What are your goals for physiotherapy? _____

Gynecological History- **please complete the following section as it applies to you.**

At what age did your period start? _____

Is your cycle regular? Yes □ No □

How long is your cycle? _____

Do you experience PMS? Yes □ No □

Do you have heavy bleeding? Yes □ No □

Do you have pain with your period? Yes □ No □

If yes, when? And how? _____

Do you use tampons? Yes □ No □

If yes, do you have pain with insertion? Yes □ No □

Do you have excessive discharge? Yes □ No □

Are you sexually active? Yes □ No □

Do you take birth control? Yes □ No □

If yes, what type? _____

Pelvic initial intake form continued…

Do you experience pain with intercourse? Yes ☐ No ☐

Do you use lubrication? Yes ☐ No ☐

If yes, what? _____

Number of pregnancies: _____ Number of live births: _____

Weight of heaviest baby: _____ Length of pushing stage of heaviest baby: _____

Number of C-sections: _____ Number of vaginal deliveries: _____

Birth-related Questions- **please complete the following section if it applies to you.**

Did you have an epidural? Yes ☐ No ☐

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

Were forceps used? Yes ☐ No ☐

Did you have an episiotomy? Yes ☐ No ☐

Did you have any tearing? Yes ☐ No ☐

Were there times during labour/delivery you were (or thought you were) in danger? Yes ☐ No ☐

Were there times the baby was (or was thought to be) in danger? Yes ☐ No ☐

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

Have you gone through menopause? Yes ☐ No ☐

Do you experience vaginal dryness? Yes ☐ No ☐

Are you undergoing any hormone therapy? Yes ☐ No ☐

If yes, what? _____

Do you have feelings of heaviness/ pressure in your vagina? Yes ☐ No ☐

Have you ever been told you have a prolapse? Yes ☐ No ☐

Prostate/Penile Health- **please complete the following section as it applies to you.**

When was your last PSA? _____

Last PSA score: _____

When was your last digital rectal exam? _____

Pelvic initial intake form continued…

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

Has your prostate fluid been 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 ☐

If yes, when? _____

Medical Procedure History- **please check any that apply and add the approximate date below.**

Appendectomy ☒	Bartholin Cyst ☒	Bowel resection ☒	Laparoscopy ☐	Cystoscopy ☐
Colonoscopy ☐	TVT-TVT (o) ☐	Gallbladder removal ☐	Hemorrhoid surgery ☐	Mesh procedure ☐
Prolapse repair ☐	Hysterectomy ☐	Colostomy ☐	Vasectomy ☐	Prostatectomy ☐
Hernia repair ☐	Urodynamic ☐	Other:		

Bladder Symptoms- **please complete the following section as it applies to you.**

Did you have problems with your bladder in 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 have a strong urge that feels uncontrollable? Yes ☐ No ☐ Sometimes ☐

Do you have pain when your bladder fills? Yes ☐ No ☐ Sometimes ☐

Do you have pain when you void? Yes ☐ No ☐ Sometimes ☐

Does your pain improve when you void? Yes ☐ No ☐ Sometimes ☐

Do you have to strain to empty your bladder? Yes ☐ No ☐ Sometimes ☐

Do you difficulty starting your urine stream? Yes ☐ No ☐ Sometimes ☐

Do you have dribbling after your get up from the toilet? Yes ☐ No ☐ Sometimes ☐

Pelvic initial intake form continued…

Do you sit on the toilet? Yes ☐ No ☐ Sometimes ☐

Do you have incomplete emptying when you void and feel like you have to go again? 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 ☐

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

Do you void during the day more than 5-7x a day? Yes ☐ No ☐ Sometimes ☐

If yes or sometimes, how often? _____

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

If yes or sometimes, how often? _____

Fluid Intake in 24 Hours

How many cups of each do you have per day?

Water: _____ Coffee: _____

Tea: _____ Other: _____

Alcohol: _____

Digestion and Bowel Function- **Please answer the following questions as it applies to you.**

What is the frequency of your bowel movements? _____times a day _____times a week

Do you regularly feel the urge to move your bowels? Always ☐ Rarely ☐ Never ☐ Do you have constipation? Always ☐ Rarely ☐ Never ☐ Do you strain to have a bowel movement? Always ☐ Rarely ☐ Never

Do you have loose stool/ diarrhea? Always ☐ Rarely ☐ Never ☐

Do you have bowel urgency that is difficult to control? Always ☐ Rarely ☐ Never ☐

Do you lose control of your bowels? Always ☐ Rarely ☐ Never ☐

Do you have incomplete emptying? Always ☐ Rarely ☐ Never ☐

Do you have pain WITH a bowel movement? Always ☐ Rarely ☐ Never ☐

Do you have pain AFTER a bowel movement? Always ☐ Rarely ☐ Never ☐

Does it take longer than 5 minutes to have a bowel movement? Always ☐ Rarely ☐ Never ☐

Pelvic initial intake form continued…

Do you have bloating? (increased pressure in your abdomen) Always ☐ Rarely ☐ Never ☐

Do you experience a physical change in abdominal girth when your bowels are full? (distention) Always ☐ Rarely ☐ Never ☐

How 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 ☐ Ulcerative Colitis ☐ Chron's Disease ☐ Celiac Disease

Medical History- Please answer the following questions to the best of your abilities, as it applies to you.

Do you get urinary tract infections? Yes ☐ No ☐

If yes, how often? _____

When was your last UTI? _____

Do you have any food allergies/ sensitivities? Yes ☐ No ☐

Have you taken antibiotics recently? Yes ☐ No ☐

If yes, how often? _____

Do you take any probiotics? Yes ☐ No ☐

If yes, what is it? _____

Do you smoke? Yes ☐ No ☐

If yes, how many packs per day? _____

Do you have a chronic cough? Yes ☐ No ☐

Do you get yeast infections? Yes ☐ No ☐

If yes, how often? _____

What treatment did you use? _____

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

Do you exercise? Yes ☐ No ☐

If yes, what type and what frequency? _____

Do you experience low back pain? Yes ☐ No ☐

Pelvic initial intake form continued…

Do you experience mid back problems? Yes ☐ No ☐

Do you have neck problems? Yes ☐ No ☐

Are any of those conditions chronic? Yes ☐ No ☐

If yes, what? _____

Have you ever been treated for depression? Yes ☐ No ☐

If so, what treatment? _____

Is/ was the treatment effective? Yes ☐ No ☐

Have you ever been treated for anxiety? Yes ☐ No ☐

If so, what treatment? _____

Is/ was the treatment effective? Yes ☐ No ☐

Have you ever been diagnosed with a mental health condition? Yes ☐ No ☐

If yes, what? _____

On a scale of 1-10, please rate how much the current **presenting problem** bothers you by circling a number below:

1- no pain 10- severe pain

1	2	3	4	5	6	7	8	9	10

On a scale of 1-10, please rate how motivated you are to correct the **presenting problem** by circling a number below:

1- not motivated 10- very motivated

1	2	3	4	5	6	7	8	9	10