PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment:
The term “informed consent” means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction. Treatment may also include ____________

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist.

Potential benefit: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:
I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Cooperation with treatment:
I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of Physical Therapy Your Way and Advanced Specialty Care.

Date ___________ Patient Name: ________________________________

(Please Print)

_________________________ ________________
Patient Signature Signature of Parent or Guardian (If applicable)

_________________________
Witness Signature
PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms

Your answers to the following questions will help us to manage your child's care better. Please complete all pages prior to your child's appointment.

Name of parent or guardian completing this form

Child’s name: ___________________________ Date: ___________________________

Age: _______________________ Grade: _______________________ Height: _______________________ Weight: _______________________ 

Describe the reason for your child's appointment ____________________________________________

When did this problem begin? Is it getting better, worse, variable, staying the same, variable? (circle one)

Name and date of child’s last doctor visit ___________________________ Date of last urinalysis: ___________________________

Previous tests for the condition for which your child is coming to therapy. Please list tests and results: ____________________________________________________________

<table>
<thead>
<tr>
<th>Medications</th>
<th>Start date</th>
<th>Reason for taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
<td>__________________________</td>
<td>__________________________</td>
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<td>__________________________</td>
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<td>__________________________</td>
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</tbody>
</table>

Has your child stopped or been unable to do certain activities because of their condition? For example, embarrassed to play with friends, can't go on sleepovers, feels ashamed about leakage and avoids play dates. ____________________________________________________________

Does your child now have or had a history of the following? Explain all “yes” responses below.

<table>
<thead>
<tr>
<th>Y/N Pelvic pain</th>
<th>Y/N Blood in urine</th>
<th>Y/N Low back pain</th>
<th>Y/N Kidney infections</th>
<th>Y/N Diabetes</th>
<th>Y/N Bladder infections</th>
<th>Y/N Latex sensitivity/allergy</th>
<th>Y/N Vesicoureteral reflux</th>
<th>Grade: ________</th>
<th>Y/N Allergies</th>
<th>Y/N Neurologic (brain, nerve) problems</th>
<th>Y/N Asthma</th>
<th>Y/N Physical or sexual abuse</th>
<th>Y/N Surgeries</th>
<th>Y/N Other (please list)</th>
</tr>
</thead>
</table>

Explain yes responses and include dates

Does your child need to be catheterized? Y/N If yes, how often?

Bladder Habits

1. How often does your child urinate during the day? _________________ times per day, every _____________ hours.

2. How often does your child wake up to urinate after going to bed? _______________ times

3. Does your child awaken wet in the morning? Y/N If yes, _____________ days per week.

4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y/N

5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)

   ___ Not at all  ___ 11-30 minutes  ___ 1-2 minutes  ___ 31-60 minutes  ___ 3-10 minutes  ___ Hours

6. Does your child take time to go to the toilet and empty their bladder? Y/N

7. Does your child have difficulty initiating the urine stream? Y/N
8. Does your child strain to pass urine? Y/N
9. Does your child have a slow, stop/start or hesitant urinary stream? Y/N
10. Is the volume of urine passed usually: Large Average Small Very small (circle one)
11. Does your child have the feeling their bladder is still full after urinating? Y/N
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? Y/N
13. Fluid intake (one glass is 8 oz or one cup)
   ___ of glasses per day (all types of fluid)
   ___ of caffeinated glasses per day
   Typical types of drinks ________________________________
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e. running water, etc.) Y/N please list ________________________________

   **Bowel Habits**
15. Frequency of movements: ___ per day ___ per week. Consistency: loose___ normal___ hard___
16. Does your child currently strain to go? Y/N__________ Ignore the urge to defecate? Y/N__________
17. Does your child have fecal staining on his/her underwear? Y/N How often? ________________________________
18. Does your child have a history of constipation? Y/N__________ How long has it been a problem? __________

   **SYMPTOM QUESTIONNAIRE**

1. Bladder leakage (check all that apply)
   ___ Never
   ___ When playing
   ___ While watching TV or video games
   ___ With strong cough/sneeze/physical exercise
   ___ With a strong urge to go
   ___ Nighttime sleep wetting
2. Frequency of urinary leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day
   ___ Constant leakage
3. Severity of leakage (circle one)
   ___ No leakage
   ___ Few drops
   ___ Wets underwear
   ___ Wets outer clothing
4. Bowel leakage (check all that apply)
   ___ Never
   ___ When playing
   ___ While watching TV or video games
   ___ With strong cough/sneeze/physical exercise
   ___ With a strong urge to go
5. Frequency of bowel leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day
6. Severity of leakage (circle one)
   ___ No leakage
   ___ Stool staining
   ___ Small amount in underwear
   ___ Complete emptying
7. Protection worn (circle all that apply)
   ___ None
   ___ Tissue paper / paper towel
   ___ Diaper
   ___ Pull-ups
8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10
   0_________________________________________________10
   Not a problem Major problem
9. Rate the following statement as it applies to your child’s life today
   My child’s bladder is controlling his/her life.
   0_________________________________________________10
   Not true at all Completely true
Please identify up to three important activities that you are unable to do or are having difficulty doing as a result of your current injury or problem. Circle the number on the line that best fits your current ability. **0** being UNABLE TO PERFORM ACTIVITY and **10** being ABLE TO PERFORM ACTIVITY AT THE SAME LEVEL AS BEFORE INJURY OR PROBLEM.

<table>
<thead>
<tr>
<th></th>
<th>UNABLE</th>
<th>ABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
</tbody>
</table>

**Medical History**

Please mark Yes or No for each of the following. Any YES answers please explain.

### Cardiovascular System:

- **Lightheadedness**
- **Heart disease**
- **Pacemaker**
- **High Blood Pressure**
- **Chest pains with rest**
- **Night sweats**
- **Shortness of breath**
- **Excessive sweating**
- **Heartbeat in abdomen when you lie down**
- **Leg cramps when walking several blocks**

### Pulmonary System:

- **Difficulty or labored breathing**
- **Prolonged cough**
- **Lung/Asthma**
- **Smoke/tobacco use**

### Blood Born Diseases:

- **HIV**
- **West Nile Virus**
- **Hepatitis A, B or C**
- **Lyme’s Disease**

### Gastrointestinal & Urogenital System:

- **Diarrhea or constipation**
- **Abdominal pain**
- **Pain or difficulty when urinating**
- **Leak urine w/cough, sneeze or exercise**
- **Changes in menstruation pattern (female)**
- **Currently pregnant**
**Endocrine System:**

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexplained weight loss or gain</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Thyroid problems</td>
</tr>
<tr>
<td>Easy bruising</td>
</tr>
</tbody>
</table>

**Nervous System/Musculoskeletal**

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you fallen with injury and/or fallen</td>
</tr>
<tr>
<td>2 or more times in the past year?</td>
</tr>
<tr>
<td>Dizziness</td>
</tr>
<tr>
<td>Gait or balance disturbances</td>
</tr>
<tr>
<td>Neurological problems/stoke</td>
</tr>
<tr>
<td>Abnormal Numbness, pins, needles</td>
</tr>
<tr>
<td>Muscle weakness</td>
</tr>
<tr>
<td>Headaches</td>
</tr>
<tr>
<td>Changes in vision</td>
</tr>
<tr>
<td>Arthritis /Joint problems</td>
</tr>
<tr>
<td>Night pain</td>
</tr>
<tr>
<td>Trauma</td>
</tr>
<tr>
<td>Morning stiffness</td>
</tr>
<tr>
<td>Prolonged use of corticosteroids</td>
</tr>
</tbody>
</table>

**Integumentary System:**

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in skin color or nail integrity</td>
</tr>
</tbody>
</table>

**General:**

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Surgeries</td>
</tr>
<tr>
<td>Fever/Chills</td>
</tr>
<tr>
<td>Unusual swelling/edema</td>
</tr>
<tr>
<td>Other medical conditions</td>
</tr>
</tbody>
</table>

Any additional explanations: ____________________________________________________________

___________________________________________________________________________________
### Appendix B

**Dysfunctional Voiding and Incontinence Symptoms Score (DVISS) Questionnaire**

1. Does your child wet during the day?  
   - No (0)  
   - Sometimes (3)  
   - Always (5)  

2. How wet is your child during the day?  
   - Damp underwear (0)  
   - Damp pants (3)  
   - Pants soaking wet (5)  

3. Does he/she wet the bed?  
   - No (0)  
   - 1-2 nights/wk (1)  
   - 3-5 nights/week (3)  
   - 6-7 nights/wk (5)  

4. How wet is your child during the night?  
   - N/A (0)  
   - Damp underwear (1)  
   - Damp/soak wet bed (4)  

5. How many times does your child urinate?  
   - 1-7 times/day (0)  
   - More than 7 times/day (1)  

6. My child strains during voiding.  
   - No (0)  
   - Yes (4)  

7. My child feels pain during voiding.  
   - No (0)  
   - Yes (1)  

8. My child voids intermittently.  
   - No (0)  
   - Yes (2)  

9. My child needs to go back to the bathroom soon after he/she finishes.  
   - No (0)  
   - Yes (2)  

10. My child has a sudden feeling of having to urinate.  
    - No (0)  
    - Yes (1)  

11. My child holds by crossing his/her legs.  
    - No (0)  
    - Yes (2)  

12. My child wets on the way to the toilet.  
    - No (0)  
    - Yes (2)  

13. My child does not have a BM daily.  
    - No (0)  
    - Yes (1)  

**Total**

---

**Quality of Life**

If your child experiences symptoms mentioned above, does it affect his/her family, social or school life?

- No=1
- Yes=2
- Seriously affects =3
PT Your Way & Advanced Specialty Care
Patient Registration and Authorization Form

Please Print

Today’s Date: ___________________ Diagnosis: ___________________ Date of Birth: ___________________

Patient Name: First_________________ Last_________________
Social Security #: __________________ Male_____ Female_____ Married_____ Single_____ Widowed_____ 

Home Address: ____________________________________________
City: ___________________________________ State: ___________ Zip Code: ___________________

Phone Numbers: Home: ___________________ Cell: ___________________
Work: ___________________ Email Address: ___________________
Employer: ___________________ Occupation: ___________________

Who can we thank for sending you to PT Your Way? ____________________________________________
M.D. _____ Friend _____ Insurance Co. _____ Internet _____ Other ___________________

Is this treatment related to an auto accident Yes _____ No _____ If YES, Injury Date ___________________

Have you had any physical/occupational/speech therapy this calendar year? Yes _____ No _____ # of visits____

Referring Physician: ___________________ Phone # ___________________
Primary Care Physician: ___________________ Phone # ___________________

Primary Insurance Company: ________________________________________________
Policy Holder: ___________________ Policy Holder Date of Birth: ___________________
Relationship: ___________________ Social Security #: ___________________
Policy Holder Employer: ___________________

Secondary Insurance Company: ________________________________________________
Policy Holder: ___________________ Relationship: ___________________
Policy Holder Date of Birth: ___________________ Social Security #: ___________________

Tertiary Insurance Company: ________________________________________________
Policy Holder: ___________________ Policy Holder Date of Birth: ___________________
Relationship: ___________________ Social Security #: ___________________

Workman’s Compensation Claim #: ___________________ Injury Date: ___________________
Adjuster and Agency: ___________________________________ Phone # ___________________

Emergency Contact: ____________________________________________
Phone # ___________________ Relationship: ___________________

The undersigned agrees to be ultimately responsible for payment of all charges for services rendered by PT Your Way & Advanced Specialty Care whether or not such services are covered by insurance benefits. The undersigned agrees to reimburse PT Your Way & Advanced Specialty Care for any expenses, including reasonable attorney fees, incurred in connection with the collection of sums due for services performed hereunder.

Patient/Responsible Party Signature: __________________________________ Date: ___________________
Policies and Procedures
Please read and initial each paragraph and sign the last page

Physical Therapy Your Way & Advanced Specialty Care takes the quality of your health care very seriously. Our model enables us to provide the highest level of specialized care possible. Unlike other physical therapy practices, we are proud to offer one-hour individual appointment sessions with a licensed physical therapist who specializes in treating complex conditions. Our patient centered, holistic approach allows exceptional results and a high rate of patient satisfaction.

_____ (initial) Payment Policy: (Excluding Medicare Patients)

Our fee is $136 per visit. Please come prepared to make a payment at each visit. We accept cash, check and major credit cards. We require a credit card to be maintained on file for charging visit fees, medical supplies, no show and late cancel fees. To avoid the charges being run on the credit card on file you may still pay for patient responsible charges with cash, check or HSA/FSA cards by presenting these at the front desk prior to your treatment. At the end of each treatment session, you will receive an itemized bill that you can submit to your insurance company. Although we are here to assist you with understanding your insurance coverage, any reimbursement from an insurance company is the responsibility of the patient.

_____ (initial) Payment Policy: Medicare Patients

I hereby agree to pay any and all charges that are not covered by my insurance plan, such as deductible, coinsurance, copayments, medical supplies, no show and late cancel fees. We require a credit card to be maintained on file for charging any fees determined to be patient responsibility. You may still pay for patient responsible charges with cash or check prior to your treatment to avoid the charges being run on the credit card on file.

_____ (initial) Cancellation Policy:

Please contact our office at least 24 business hours prior to your scheduled appointment to notify us of any cancellations. If 24-hour notification is not given, you will be charged $60 for the missed appointment. This amount will be collected directly from your credit card on file. To cancel a Monday appointment, please call our office by 4:00 p.m. on Friday. If over the weekend you need to cancel a Monday appointment, please leave a message as soon as possible so we can attempt to fill the appointment first thing Monday morning. If we fill your appointment slot you will not be charged.
(initial) **No Show Policy:**
If you fail to show up for a scheduled appointment a $60 no show fee will be charged to you. This amount will be collected directly from your credit card on file.

(Initial) **Late Policy:**
If you think you will be late for your scheduled appointment please call and inform us. We will try to accommodate you however your treatment session time may be reduced in order to remain on time for the courtesy of the next scheduled patient. **If you are late you will still be charged for your full hour treatment session.** (Not applicable to Medicare patients)

(Initial) **We do understand that unforeseen matters of sickness or emergencies occur that you cannot control. Unfortunately we still need to charge for these missed appointments.** Thank you for your understanding and cooperation.

(Initial) **Appointment Reminders:**
We offer automated reminder phone calls, text messages or emails as a courtesy to our clients, however it is ultimately your responsibility to attend your scheduled appointment. Please be sure that the phone number or email you have provided us is correct in order to receive these reminder messages.

**I prefer to receive appointment reminders by:**

Please circle one: **Phone Call**    **Email**    **Text Message**    **None**

Please list the appropriate phone number or email: _____________________________

(Initial) **Return Check Fee:**
If checks are returned from the bank there will be a $20 returned check fee assessed to your account. This amount will be collected directly from your credit card on file.

(Initial) **HIPAA:** I have read and understand I have rights to a copy of Physical Therapy Your Way’s HIPAA privacy notice. I have the right to request restrictions on the use of my information and to revoke my consent at a later date.

Thank you for trusting us with your specialized physical therapy needs. I have read and fully understand the above policies and procedures of Physical Therapy Your Way P.L.C. and agree to these terms.

Signature of Patient/Responsible Party: _________________________________________
Date: ____________________________