Your Daily Bladder Diary

This diary will help you and your health care team figure out the causes of your bladder control trouble. The "sample" line shows you how to use the diary.

Your name: _____

Date: _____

Time	Drinks		Trips to the Bathroom		Accidental Leaks	Did you feel a strong urge to go?	What were you doing at the time?
	What kind?	*How much?*	*How many times?*	*How much urine? (circle one)*	*How much? (circle one)*	*Circle one*	*Sneezing, exercising having sex, lifting, etc.*
Sample	Coffee	2 cups	✓✓	(sm) med lg	sm (med) lg	Yes (No)	Running
6–7 a.m.				sm med lg	sm med lg	Yes No	
7–8 a.m.				sm med lg	sm med lg	Yes No	
8–9 a.m.				sm med lg	sm med lg	Yes No	
9–10 a.m.				sm med lg	sm med lg	Yes No	
10–11 a.m.				sm med lg	sm med lg	Yes No	
11–12 noon				sm med lg	sm med lg	Yes No	
12–1 p.m.				sm med lg	sm med lg	Yes No	
1–2 p.m.				sm med lg	sm med lg	Yes No	
2–3 p.m.				sm med lg	sm med lg	Yes No	
3–4 p.m.				sm med lg	sm med lg	Yes No	
4–5 p.m				sm med lg	sm med lg	Yes No	
5–6 p.m.				sm med lg	sm med lg	Yes No	
6–7 p.m.				sm med lg	sm med lg	Yes No	

Use this sheet as a master for making copies that you can use as a bladder diary for as many days as you need.

Time	Drinks		Trips to the Bathroom		Accidental Leaks	Did you feel a strong urge to go?	What were you doing at the time?
	What kind?	*How much?*	*How many times?*	*How much urine? (circle one)*	*How much? (circle one)*	*Circle one*	*Sneezing, exercising having sex, lifting, etc.*
Sample	Soda	2 cans	✓✓	(sm) med lg	(sm) med lg	Yes (No)	Running
7–8 p.m.				sm med lg	sm med lg	Yes No	
8–9 p.m.				sm med lg	sm med lg	Yes No	
9–10 p.m.				sm med lg	sm med lg	Yes No	
10–11 p.m.				sm med lg	sm med lg	Yes No	
11–12 midnight				sm med lg	sm med lg	Yes No	
12–1 a.m.				sm med lg	sm med lg	Yes No	
1–2 a.m.				sm med lg	sm med lg	Yes No	
2–3 a.m.				sm med lg	sm med lg	Yes No	
3–4 a.m.				sm med lg	sm med lg	Yes No	
4–5 a.m.				sm med lg	sm med lg	Yes No	
5–6 a.m.				sm med lg	sm med lg	Yes No	

I used _____ pads today. I used _____ diapers today (write number).

Questions to ask my health care team: _____

_____

_____

_____

_____

Let's Talk About Bladder Control for Women is a public health awareness campaign conducted by the National Kidney and Urologic Diseases Information Clearinghouse (NKUDIC), an information dissemination service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health.

PFDI- 20 Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the **last 3 months**.

The PFDI-20 has 20 items and 3 scales of your symptoms.
All items use the following format with a response scale from 0 to 4.

Symptoms Present = YES, scale of bother: 1 = not at all
2 = somewhat
3 = moderately
4 = quite a bit

Symptoms Not Present = NO 0 = not present

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you ...	No	Yes
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal Distress Inventory 8 (CRAD-8):

Do you ...	No	Yes
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary Distress Inventory 6 (UDI-6):

Do you ...	No	Yes
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20:

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PFSI-20 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).

PFIQ – 7 Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question place an **X** in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in all 3 columns for each question.

How do symptoms or conditions relating to the following → → → Usually affect your …↓	***Bladder or urine***	***Bowel or rectum***	***Vagina or pelvis***
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. Emotional health (nervousness, depression, etc.)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

All of the items use the following response scale:

0 = not at all; 1 = somewhat, 2 = moderately, 3 = quite a bit

Scales:

Urinary Impact Questionnaire (UIQ-7); 7 items under column heading "Bladder or urine."
Colorectal-Anal Impact Questionnaire (CRAIQ-7): 7 items under column heading "Bowel or rectum."
Pelvic Organ Prolapse Impact Questionnaire (POPIQ-7): 7 items under column heading "Pelvis or vagina."

Scale scores: Obtain the mean value for all of the answered items within the corresponding scale (possible value 0 to 3) and then multiply by 100/3) to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.
Total score of each section _____ divided by 7 _____ X 33.3 = _____

PFIQ-7 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).

Barber, M., Walters, M., et al. (2005). "Short forms of two condition-specific quality of life questionnaires for women with pelvic floor disorders (PFDI-20 and PFIQ -7)." American Journal of Obstetrics and Gynecology 193: 103-113.

New Physical Therapy
Patient Information Sheet

Name: _____

Date of Birth:_____ **Age:**_____ **SS#:**____

Mailing Address: _____
City/State/Zip: _____

Home#:_____ **Cell#:**_____
Work #:_____

How may we contact you? (circle one) Home Cell Work **Email:** __
May we leave a detailed message on your machine? Y N
If not, who may we leave the message with?_____

Occupation:_____**Employer:**_____

Marital Status: S M D W **Spouse Name:**____

Emergency Contact:_____ **Phone #:**_

******Please provide us with your Physician's referral, copy of ALL insurance cards, and copy of driver's license******

Referring Physician:_____ **Referral Date:**_____

******I am aware that I may be responsible for fulfilling a deductable before my insurance begins payment******

Primary Insurance Company:_____
ID#:_____ **GRP#**_____

Policy Holder:_____ **Policy Holder Date of Birth:**_____

Secondary Insurance Company:_____
ID#:_____

PATIENTS:
ATTENTION MEDICARE

Are you currently enrolled in Home Health Care?
Yes or no

WORKMAN'S COMPENSATION/INJURY RELATED INSURANCE:

Company:_____ **Date of Injury:**_____ **Name of Insured:**_____
Claim #:_____ **Adjustor's Name:**___
Phone #:_____ **Mailing Address:**___

I authorize MedX of Estes to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to MedX of Estes. I agree that a reproduced copy of the authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance.

I understand that it is possible for physical therapy to initially increase my symptoms. The physical therapist may perform tests during the initial visit, which may increase my symptoms. This is a normal physiological response.
I consent to and authorize ofMedX of Estes to administer all treatments and services that may be considered advisable in the judgment of my physician and/or therapist in accordance withMedX's policies.

Signature of responsible party:
Date: _____

MedX of Estes Physical Therapy

Patient History

Name _____ **Age**_____ **Date**_____

1. Describe the current problem that brought you here?_____
_____

2. When did your problem first begin?___Months ago or ___ years ago.

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____
_____

4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how?_____

5. If pain is present rate pain on a 0-10 scale 10 being the worst._____ Describe the nature of the pain (i.e. constant burning, intermittent ache)_____
_____

6. Describe previous treatment/exercises_____
_____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ sitting greater than_____ minutes
___ walking greater than _____minutes
___ standing greater than _____ minutes
___ Changing positions (i.e. - sit to stand)
___ light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ other, please list _____

___ with cough/sneeze/straining
___ with laughing/yelling
___ with lifting/bending
___ with cold weather
___ with triggers -running water/key in door
___ with nervousness/anxiety
___ No activity affects the problem

8. What relieves your symptoms?_____
_____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst __

11. What are your treatment goals/concerns?_____
_____

Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling

Y/N Other /describe_____
_____

Health History: Date of Last Physical Exam _____ Tests performed_____

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
Mental Health: Current level of stress High___ Med___ Low___ Current psych therapy? Y/N
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____

Have you ever had any of the following conditions or diagnoses? circle all that apply / describe

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe_____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries #___	Y/N	Vaginal dryness
Y/N	Episiotomy #___	Y/N	Painful periods
Y/N	C-Section #____	Y/N	Menopause - when? ___
Y/N	Difficult childbirth #_____	Y/N	Painful vaginal penetration
Y/N	Prolapsed or organ falling out	Y/N	Pelvic pain
Y/N	Other /describe_____		

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic pain		
Y/N	Other /describe_____		

Medications - pills, injection, patch	Start date	Reason for taking

Over the counter -vitamins etc	Start date	Reason for taking

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine
Y/N	Urinary intermittent /slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/ fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/ fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections
Y/N	Other/describe _____		

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all
3. The usual amount of urine passed is: ___small ___ medium___ large.
4. Frequency of bowel movements ____ times per day, _____times per week, or _____.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all.
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
   Of this total how many glasses are caffeinated?____ glasses per day.
8. Rate a feeling of organ "falling out" / prolapsed or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your period)
___With standing for _____ minutes or _____hours.
___With exertion or straining
___Other

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

11. What form of protection do you wear? (Please complete only one)

___None
___Minimal protection (Tissue paper/paper towel/panty shields)
___Moderate protection (absorbent product, maxi pad)
___Maximum protection (Specialty product/diaper)
___Other _____

On average, how many pad/protection changes are required in 24 hours? _____# of pads

A. Notifier: MedX of Estes

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Physical Therapy below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Physical Therapy below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy	Met Hard Cap Limit	$75.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Physical Therapy listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** Physical Therapy listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** Physical Therapy listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** Physical Therapy listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Financial Policy for MedX of Estes

Thank you for choosing MedX for your Physical Therapy needs. We are dedicated to providing you with the best possible care and service. We want you to understand of our financial policy before beginning your care and treatment at MedX. We require you to read and understand the following information prior to your treatment.

You must complete our patient registration forms and present a copy of your driver's license and insurance card to the front desk. You are responsible for notifying us of ANY and ALL changes to your insurance coverage, address, phone numbers, and employment status.

INSURED PATIENTS: We have written provider contracts with many insurance plans. We will file claims with those insurance plans with which we are contracted. Please advise if you have received physical therapy or chiropractic treatment at another facility this fiscal year that may affect your insurance benefits.
You are responsible for knowing the terms and conditions of your insurance policy including those regarding referrals and prior authorizations. Obtaining referrals and authorizations from your insurance company often takes 48 hours or longer.
Insurance contracts state that you may be responsible for:
- Co-pays (paid at each visit)
- Deductibles
- Co-Insurance Expenses
- Supplies (not covered by your insurance)

In the event that your health plan determines a service is not covered, or applies the service to your deductible or coinsurance, full payment for these services is due upon receipt of a statement from MedX of Estes. Once insurance has made payment for services we will then bill you for the remaining collections.

The billing process and prices are set by the Health Care Financing Administration (HCFA) and follow the Colorado Standard for pricing and billing. MedX of Estes will accept all reimbursements that your personal insurance policy allows and you will not be responsible for what is not allowed by your policy. We will bill you accordingly.

Non-Insured Patients: *Full payment is due at time of service.* For your convenience we accept cash, check, Master Card and Visa.
Minor Patients: The adult and/or parent accompanying the patient or requesting the treatment is responsible for full payment of services as described above. Non-accompanied minors coming in for treatment must have prior approval from their parents or guardian in order to be treated. Payment must accompany the patient.
Minors of Divorced Parents: The parent accompanying the patient or requesting the treatment is responsible for full payment of services as described above for insured or non-insured patients, regardless of the divorce decree or settlement. **It is the requesting parent's responsibility to know the terms and limits of their insurance policy.**
Missed Appointments: In order to provide the best possible service and availability to all of our patients, we request that you call during business hours at least 24 hours in advance to cancel your appointment. ***Our policy is to bill you $25.00 for appointments that are canceled with less then 24 hours and more than 4 hours notice. Appointments cancelled within 4 hours or "no show" appointments, will be billed at $45.00.*** You will be responsible for the payments as most insurance companies do not pay for missed appointments.

Thank you for choosing MedX of Estes for your treatment. If you have any questions regarding our financial policy and/or your financial responsibilities, please contact our billing department.

I have read and understand the above policy and I agree to the terms of the policy.

Signature of Responsible Party _____ Date _____

MedX of Estes Physical Therapy
PATIENT PRIVACY AND PROCEDURE STATEMENT

MedX of Estes maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with the state law.

We protect all patient information within the guidelines provided by federal, state and local government.

If you have grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Office Manager, at (970) 577-0174.

MedX of Estes Physical Therapy reserves the right to amend, change and/or revise our privacy policy at any time in accordance with federal, state and local rules, regulation and guidelines.

_____	_____
Signature	Date/2016
_____	_____
Signature	Date/2017
_____	_____
Signature	Date/2018