WELCOME TO COMPLETE WELLNESS CLINIC

Take the first step to wellness!

Your first appointment involves an assessment by a Registered Physiotherapist. Please read our website for more information.

You may be asked to wear a gown or shorts in order to allow the physiotherapist to view the area to be treated. For subsequent visits, it is important to wear comfortable clothing so that you can fully participate. At **Complete Wellness Clinic**, education is a crucial part of our treatment philosophy. We encourage questions so please do not hesitate to voice or email (milton@complete-wellness.ca) any concerns or comments you may have to your physiotherapist.

OUR FEES

Type of Appointment	Pelvic Health Physiotherapy	MSK Physiotherapy
Initial Assessment	$110	$90
Subsequent Visit	$90	$60

Please read the following procedures carefully, prior to consenting to treatment.

- **Complete Wellness Clinic** is a private chiropractor owned clinic and as a result **we do not have OHIP billing privileges.** Physiotherapy treatment may be covered by either extended health insurance plans through your employment, motor vehicle accident insurance from a car accident or WSIB if your injury is work related. Please let us know which method upon first assessment. Please be sure to check into the details of your coverage since every plan is different, and it is the client's responsibility to understand any limitations to your coverage
- **Complete Wellness Clinic** requires **payment at the time services are rendered**. Payment can be made by cash, cheque, debit, Visa/MC.
- If you cannot attend an appointment, please give **24 HOURS NOTICE** so that another patient may receive care during that time. If you cannot cancel with 24 hours' notice, you will be billed for untimely or missed appointments.
- In order to receive the best medical care from all providers, we would ask that you notify your physiotherapist if you have an upcoming doctor's appointment so that a progress note can be forwarded to your doctor. Also, please notify your physiotherapist of any related investigations that have been done so copies can be obtained if necessary.

I have read and give my consent to the above specifications.

______________________________ ______________________________ ______________

Client's signature **Name (please print)** **Date**

______________________________ ______________________________________

Parent/Guardian signature **Parent/Guardian Name (Please Print)**

Signature of Parent/Guardian consenting to assume financial responsibility if client is under age 18

INFORMED CONSENT FOR PELVIC HEALTH PHYSIOTHERAPY

On September 1, 2011 physiotherapists' performance of Authorized Activities was revised to include "putting an instrument, hand, or finger beyond the labia majora or the anal verge for the purpose of assessing or rehabilitating pelvic floor muscles relating to incontinence or pain disorders." This activity was directly authorized by the Physiotherapy Act and may only be performed by **physiotherapists with appropriate post-graduate training**.

Conditions that could include pelvic floor physiotherapy as part of assessment and treatment include:

- Urinary incontinence (stress, urge, or mixed)
- Pelvic organ prolapse (hysterocele, cystocele, or rectocele)
- Chronic pelvic pain (including vaginal, perineal, or rectal)
- Vulvodynia/vestibulodynia
- Vaginissmus or dyspareunia (painful intercourse)
- Interstitial cystitis
- Non-bacterial prostatitis
- Pregnancy-related pelvic girdle pain
- Chronic low back, sacroiliac joint, and/or hip pain

The **benefits** of doing an internal pelvic floor exam include:

- Determining the resting tone of the pelvic floor muscles (normal, hypo/hypertonic)
- Assessing the ability to contract the pelvic floor muscles (including the timing, coordination, strength, and endurance)

There are some **risks** with doing an internal pelvic floor exam, including:

- Urinary tract infection
- Pain (during or after the assessment)
- Spotting
- Pre-term labour (if pregnant)

After the assessment and treatment, if I experience any of these adverse effects, I will inform my physiotherapist as soon as possible. My physiotherapist will advise me whether I should monitor my condition or seek medical attention.

I acknowledge that I have informed my physiotherapist of all my health issues and concerns (past and present) including malignant and inflammatory diseases, history of urinary tract infections, and pregnancy. I have also disclosed other treatment options, including other health care providers that I am currently seeing or have seen for this condition.

Signing below indicates that I understand the above (including the indications, benefits, and potential adverse effects of pelvic floor exam and treatment) and **I consent to having an internal pelvic floor muscle exam**. I understand that an internal pelvic floor muscle exam, as well as internal muscle release techniques and/or strengthening exercises, will part of my subsequent treatments. I also understand that I can withdraw my consent at any time.

Patient Name	Patient Signature	Date
Witness Name	Witness Signature	Date

Complete Wellness Clinic
milton@complete-wellness.ca
450 Bronte St. S, Milton ON, L9T 8T2
Tel: (905) 875-2288

completewellness clinic 905-875-2288

Name: ______________ Date: ______________

Occupation: ______________ Hobbies: ______________

Complaints 1. ______________

2. ______________

When did it start? ______________

How did it start? ______________

LOSS OF CONTINENCE ☐ **Yes** ☐ **No (don't fill in chart)**

Please put an **X** next to the statements that best describe your symptoms:

☐ My incontinence is associated with activities such as sneezing, running or coughing ☐ daily ☐ weekly

S

☐ My incontinence is preceded by a strong sensation that feels uncontrollable ☐ daily ☐ weekly

U

☐ My incontinence is associated with frequency of urination during the day (>5-7 X/day) __ # times per day

F

☐ My bladder troubles cause frequent nighttime urination __ # times/night

N

☐ My incontinence is associated with frequent nighttime bedwetting __ # times/week

☐ My incontinence requires me to wear pads __ # pads/day

☐ My bladder troubles include incomplete emptying

R

☐ I have pain when I urinate ☐ yes ☐ no ☐ sometimes

☐ I have to strain when I urinate ☐ yes ☐ no ☐ sometimes

TP

☐ I have leakage during intercourse ☐ yes ☐ no ☐ sometimes

☐ I had problems with urination during my childhood ☐ yes ☐ No

#____cups of coffee/day #____cups of water/day #____cups of tea/day # _____ cups of other fluids/day

Do you have trouble sleeping? ☐ Yes ☐ No If yes, ☐ Trouble falling to sleep? ☐ Trouble Staying Asleep?

HISTORY (women only):

pregnancies: ___ # live births: ___ Wt. heaviest baby: ___ lbs ___ oz Length pushing stage: ______ hours

Forceps? ☐ Yes ☐ No Episiotomies? ☐ Yes ☐ No Tears? ☐ Yes ☐ No

HRT? ☐ Yes ☐ No When? _________ Last pap: ______________ Normal? ☐ Yes ☐ No

Sexually Active? ☐ Yes ☐ No Pain with sex? ☐ Yes ☐ No When? ☐ Penetration ☐ Thrusting?

Complete Wellness Clinic
milton@complete-wellness.ca
450 Bronte St. S, Milton ON, L9T 8T2
Tel: (905) 875-2288

SURGICAL HISTORY (Male and Female):

Abdominal: ☐ When: ____________________

Pelvic: ☐ When: ____________________

BOWEL HISTORY:

Frequency: __ /week

Fecal Incontinence: ☐ Yes ☐ No

Fecal Urgency: ☐ Yes ☐ No

Constipation: ☐ Yes ☐ No

Stool consistency ☐ Loose ☐ Soft/Formed ☐ Hard ☐ Varies

MEDICAL HISTORY:

Urinary Tract Infections ☐ Yes ☐ No

Smoking: ☐ Yes ☐ No ___ #packs/day

Chronic Cough: ☐ Yes ☐ No

Asthma: ☐ Yes ☐ No

Allergies: ____________________

Height: ____ ft. __ In. Weight: _______ lbs

BMI: (therapist to calculate) _________

Back Problems: ☐ Yes ☐ No

Neck Problems: ☐ Yes ☐ No

Current Meds: ____________________

Previous Rx (incl. meds): ____________________

____

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

	Delighted	**Pleased**	**Mostly satisfied**	**Mixed**	**Mostly dissatisfied**	**Unhappy**	**Terrible**
Initial	0	1	2	3	4	5	6
Discharge	0	1	2	3	4	5	6

On a scale from 1-10, please circle and rate your current pain/discomfort

1 2 3 4 5 6 7 8 9 10

The following questions are reproduced with permission from the International Pelvic Pain Society, www.pelvicpain.org

Please read each of the following statements and circle the number that best represents your symptoms:
0 = no pain 1 = mild pain 2 = mild-moderate pain 3 = moderate4 = moderate-severe 5 = severe symptoms

Pain:						
How would you rate your present pain……………………………………………………	0	1	2	3	4	5
Pain when lifting……………………………………………………………………………...	0	1	2	3	4	5
Pain when sitting……………………………………………………………………………..	0	1	2	3	4	5
Pain when walking……………………………………………………………………………	0	1	2	3	4	5
Pain while doing physical activity…………………………………………………………..	0	1	2	3	4	5
Deep pain with sexual intercourse or sexual activity……………………………………..	0	1	2	3	4	5
Pelvic pain lasting hours or days after sexual activity……………………………………	0	1	2	3	4	5
Pain when bladder when full…………………………………………………………………..	0	1	2	3	4	5
Pain with urination…………………………………………………………………………...	0	1	2	3	4	5
Muscle or joint pain…………………………………………………………………………..	0	1	2	3	4	5
Abdominal pain………………………………………………………………………………	0	1	2	3	4	5
Backache……………………………………………………………………………………..	0	1	2	3	4	5
Pain when wearing tight clothing…………………………………………………………..	0	1	2	3	4	5
Pain with bowel movement…………………………………………………………………	0	1	2	3	4	5
Pain after bowel movement…………………………………………………………………..	0	1	2	3	4	5
A falling-out feeling or a feeling of pressure in the pelvis………………………………	0	1	2	3	4	5
Bladder Symptoms:	0	1	2	3	4	5
Loss of urine when coughing, sneezing, lifting or laughing…………………………….	0	1	2	3	4	5
Frequency of urination versus the normal of once every 2-3 hours…………………..	0	1	2	3	4	5
Urgency or need to urinate with little warning…………………………………………...	0	1	2	3	4	5
Loss of urine due to strong urge…………………………………………………………….	0	1	2	3	4	5
Difficulty initiating urine stream……………………………………………………………	0	1	2	3	4	5
Urine stream stops and starts………………………………………………………………..	0	1	2	3	4	5
Nighttime urinary frequency…………………………………………………………………..	0	1	2	3	4	5
Incomplete emptying of urine………………………………………………………………	0	1	2	3	4	5
Bowel Symptoms:	0	1	2	3	4	5
Constipation (fewer than 3 bowel movements/week)……………………………………	0	1	2	3	4	5
Bowel frequency (more than 3 bowel movements/day)…………………………………	0	1	2	3	4	5
Incomplete emptying of bowel………………………………………………………………..	0	1	2	3	4	5
Urgency or need to have a bowel movement with little warning………………………	0	1	2	3	4	5
Abdominal bloating or fullness………………………………………………………………	0	1	2	3	4	5
Lumpy or hard stool consistency……………………………………………………………	0	1	2	3	4	5
Needing to strain to achieve bowel movement…………………………………………	0	1	2	3	4	5
Fecal incontinence……………………………………………………………………………	0	1	2	3	4	5

Complete Wellness Clinic
milton@complete-wellness.ca
450 Bronte St. S, Milton ON, L9T 8T2
Tel: (905) 875-2288

Since your symptoms began, how much as your lifestyle been affected?
0 = no effect **1** = mild affect **2** = mild-moderate affect **3** = moderate affect **4** = moderate-severe **5** = substantive change

For Women only:

Effect on Daily Life:

Symptoms or pain limits or interferes with work or school……………………………….	0	1	2	3	4	5
Symptoms or pain limits or interferes with social activities………………………………	0	1	2	3	4	5
Symptoms or pain limits or interferes with exercise routine……………………………..	0	1	2	3	4	5
Symptoms or pain limits or interferes with lifting, cleaning, carrying, shopping, etc….	0	1	2	3	4	5
Symptoms or pain limits or interferes with recreational and/or athletic activities……..	0	1	2	3	4	5
Symptoms or pain limits or interferes with sexual activity……………………………….	0	1	2	3	4	5
Symptoms or pain limits or interferes with sleep…………………………………………..	0	1	2	3	4	5
Symptoms or pain cause unexplained mood changes…………………………………..	0	1	2	3	4	5
Pain at ovulation (mid-cycle)………………………………………………………………..	0	1	2	3	4	5
Pain level just before period………………………………………………………………..	0	1	2	3	4	5
Pain (not cramps) with period………………………………………………………………	0	1	2	3	4	5
Cramps with your period…………………………………………………………………….	0	1	2	3	4	5
Pain after period is over……………………………………………………………………..	0	1	2	3	4	5
Burning vaginal pain with penetration of tampon or during sex…………………………	0	1	2	3	4	5
Difficulty achieving orgasm (even when aroused)………………………………………..	0	1	2	3	4	5

For Men only:

Effect on Daily Life:

Symptoms or pain limits or interferes with work or school………………………………	0	1	2	3	4	5
Symptoms or pain limits or interferes with social activities……………………………..	0	1	2	3	4	5
Symptoms or pain limits or interferes with exercise routine…………………………….	0	1	2	3	4	5
Symptoms or pain limits or interferes with lifting, cleaning, carrying, shopping, etc…	0	1	2	3	4	5
Symptoms or pain limits or interferes with recreational and/or athletic activities…….	0	1	2	3	4	5
Symptoms or pain limits or interferes with sexual activity………………………………	0	1	2	3	4	5
Symptoms or pain limits or interferes with sleep…………………………………………	0	1	2	3	4	5
Symptoms or pain cause unexplained mood changes…………………………………	0	1	2	3	4	5
Difficulty getting an erection (even when aroused)………………………………………	0	1	2	3	4	5
Difficulty achieving orgasm (even when aroused)……………………………………….	0	1	2	3	4	5

Male Total: _______ **/ 220**
Women Total: _______ **/ 245**

Complete Wellness Clinic
milton@complete-wellness.ca
450 Bronte St. S, Milton ON, L9T 8T2
Tel: (905) 875-2288