FOLSOM PHYSICAL THERAPY
and Training Center
Since 1983

INFORMATION ON TREATMENT FOR PELVIC FLOOR DYSFUNCTION AND BLADDER / BOWEL PROBLEMS

IMPORTANT – READ IMMEDIATELY

Please arrive at least 15 minutes early to complete necessary paperwork if not already done.

Your appointment is scheduled for _____ a.m. /p.m. on _____.

Enclosed please find:

HISTORY AND SCREENING QUESTIONNAIRES

All forms must be completed prior to your first appointment.

The office evaluation/treatment of your condition may include:

- Review of your history
- Measurement of your pelvic floor muscle function with biofeedback equipment.
  These instruments record your muscle activity and help evaluate and treat your pelvic floor muscles.
- Musculoskeletal and pelvic floor muscle exam.
- Exercise instruction for pelvic floor and other muscle groups as indicated.

Return visits for therapy will be scheduled at regular intervals to measure your progress and modify your exercise program as needed. These appointments are important in order to progress your treatment program.

Please feel free to invite someone to accompany you to your appointments if doing so will make you feel more comfortable.

If you have any questions, please telephone 916-355-8500.

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INFORMED CONSENT FOR TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to you. 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, bladder or sexual functions, painful scars after surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

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 vagina 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. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to the following: observation, palpation, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort, 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 therapist.

Potential benefits: may include 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 and/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 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 physical 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 physical therapy 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 therapist of Folsom Physical Therapy.

Patient/Guardian Name (Please Print): _____ **Date**: _____

Patient/Guardian Signature: _____

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PELVIC FLOOR PATIENT HISTORY

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 (Describe)

   _____
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, _____
   ___ 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 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_____

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Pg 2 History

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 male/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 Prolapse 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 _____

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Symptoms

Bladder / Bowel Habits / Problems

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

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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/pant 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

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

Over the counter -Vitamins etc.	Start date	Reason for taking

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BLADDER HEALTH QUIZ

1. Do you urinate more than every two hours in the daytime? Y / N
2. Do you urinate more than once after going to bed? Y / N
3. Do you have trouble making it to the toilet on time when you have an urge to go? Y / N
4. Do you strain to pass urine? Y / N
5. Do you rush to go to the toilet to empty your bladder? Y / N
6. Are you unable to stop the flow of urine when on the toilet? Y / N
7. Do you have an urge to go but when you get to the toilet very little urine comes out? Y / N
8. Do you lack the feeling that you need to go to the toilet? Y / N
9. Do you empty your bladder frequently, before you experience the urge to pass urine? Y / N
10. Do you have the feeling your bladder is still full after urinating? Y / N
11. Do you experience slow or hesitant urinary stream? Y / N
12. Do you have difficulty initiating the urine stream? Y / N
13. Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, key in the door) Y / N
14. Rate the following statement as it applies to you today.
My bladder is controlling my life. 0= not at all true 10 = completely true

0 1 2 3 4 5 6 7 8 9 10

If you answer yes to any of these questions you could benefit from conservative treatment for your bladder. Talk to your health care provider for a referral.

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