FOLSOM PHYSICAL THERAPY
and Training Center

(916) 355-8500
115 Natoma Street
Folsom, CA 95630
fpt@folsomphysicaltherapy.com

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.
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.
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.
Cancellation Policy
I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will be charged the amount of the appointment.
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.

Date:_____ Patient Name: _____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

FOLSOM PHYSICAL THERAPY
and Training Center

(916) 355-8500
115 Natoma Street
Folsom, CA 95630
fpt@folsomphysicaltherapy.com

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_____Prefers to be called_____Date_____

Age_____Grade_____Height_____Weight_____

Describe the reason for your child's appointment_____ When did this problem begin?_____Is it getting better_____worse_____staying the same_____

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_____

_____

_____

Medications	Start date	Reason for taking

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? Check all that apply.

- ☐ Pelvic pain
- ☐ Low back pain
- ☐ Diabetes
- ☐ Latex sensitivity/allergy
- ☐ Allergies
- ☐ Asthma
- ☐ Surgeries
- ☐ Blood in urine
- ☐ Kidney infections
- ☐ Bladder infections
- ☐ Vesicoureteral reflux Grade _____
- ☐ Neurologic (brain, nerve) problems
- ☐ Physical or sexual abuse
- ☐ Other (please list)

Explain yes responses and include dates_____

_____

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

FOLSOM PHYSICAL THERAPY
and Training Center

(916) 355-8500
115 Natoma Street
Folsom, CA 95630
fpt@folsomphysicaltherapy.com

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? ____ If yes,_____days per week.

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

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

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

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

7. Does your child have difficulty initiating the urine stream? _____

8. Does your child strain to pass urine? _____

9. Does your child have a slow, stop/start or hesitant urinary stream?_____

10. The volume of urine passed Is usually: ☐ Large ☐ Average ☐ Small ☐ Very small (circle/check one)

11. Does your child have the feeling their bladder is still full after urinating? _____

12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? ____

13. Fluid intake (one glass is 8oz 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_____

FOLSOM PHYSICAL THERAPY
and Training Center

(916) 355-8500
115 Natoma Street
Folsom, CA 95630
fpt@folsomphysicaltherapy.com

Bowel Habits

15. Frequency of movements:____per day_____per week_____
    - Consistency: loose☐ normal☐ hard☐

16. Does yourchild currentlystrainto go? Y/N___

17. Does your child ignore the urge todefecate? Y/N___

18. Does yourchild havefecalstainingonhis/her underwear? Y/N___How often? _____

19. Does yourchild have a historyof constipation? Y/N__ How longhas it been a problem?_____

SYMPTOM QUESTIONNAIRE

Bladder

1. Bladder Leakage (check all that apply)
   - ☐Never
   - ☐When playing
   - ☐While watching TV or Video Games
   - ☐With strong cough/sneeze/physical exercise

2. Frequency of urinary leakage-number (#) of episodes
   - __# per month
   - __# per week
   - __# per day
   - ☐Constant Leakage

3. Severity of leakage (check one)
   - ☐ No leakage
   - ☐few drops
   - ☐Wets underwear
   - ☐wets outer clothing

4. Protection Worn (check all that apply)
   - ☐None ☐Tissue paper
   - ☐Diapers ☐Pull-Ups

Bowel

2. Bowel Leakage (check all that apply)
   - ☐Never
   - ☐When playing
   - ☐While watching TV or Video Games
   - ☐With strong cough/sneeze/physical exercise

4. Frequency of bowel leakage-number (#) of episodes
   - __# per month
   - __# per week
   - __# per day
   - ☐Constant Leakage

6. Severity of leakage (check one)
   - ☐No leakage
   - ☐stool staining
   - ☐small amount in underwear
   - ☐complete emptying

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