



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

IMPORTANT – READ IMMEDIATELY

Your first appointment will take 45 to 60 minutes so plan your time appropriately. Please arrive at least 15 minutes early to complete necessary paperwork.

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

Enclosed please find:

1. HISTORY AND SCREENING QUESTIONNAIRES

All forms must be completed prior to your first appointment.

- Incomplete information may delay insurance processing and authorization for subsequent treatment.
- Prior to your first appointment we recommend you check with your insurance company regarding coverage for

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 call 916-355-8500.



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 an 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 _____



PLAN OF CARE AGREEMENT

My diagnosis, evaluation findings including the treatment program, the expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program, has all been explained to me. My questions about my care have been answered to my understanding and satisfaction.

I consent to the recommended course of treatment.

For optimum care and progress:

- It is important to keep your regularly scheduled therapy appointment. At those visits we can advance your exercise routine.
- Please avoid practicing your pelvic floor exercises just before your next appointment time.
- Bring your exercise sheets, voiding log and biofeedback internal sensors as appropriate to each office visit.

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

(Patient/Guardian) Signature: _____

Therapist Signature: _____



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, intermittentache) _____
6. Describe previous treatment/exercises _____
7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

| | |
|----------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Sitting greater than minutes | <input type="checkbox"/> With cough/sneeze/straining |
| <input type="checkbox"/> Walking greater than minutes | <input type="checkbox"/> With laughing/yelling |
| <input type="checkbox"/> Standing greater than minutes | <input type="checkbox"/> With lifting/bending |
| <input type="checkbox"/> Changing positions (i.e. - sit to stand) | <input type="checkbox"/> With cold weather |
| <input type="checkbox"/> Light activity (light housework) | <input type="checkbox"/> With triggers -running water/key in door |
| <input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump) | <input type="checkbox"/> With nervousness/anxiety |
| <input type="checkbox"/> Sexual activity | <input type="checkbox"/> No activity affects the problem |
| <input type="checkbox"/> Other, _____ | |
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? Check all that apply.

- | | | |
|------------------------------------------|-------------------------------------|-------------------------------|
| 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 _____ |



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 # _____ | Painful periods Y/N |
| Y/N C-Section # _____ | 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 _____ | |



Pg 3 History

| <u>Medications - pills, injection, patch</u> | <u>Start date</u> | <u>Reason for taking</u> |
|----------------------------------------------|-------------------|--------------------------|
| | | |
| | | |
| | | |

| <u>Over the counter -Vitamins etc.</u> | <u>Start date</u> | <u>Reason for taking</u> |
|----------------------------------------|-------------------|--------------------------|
| | | |
| | | |
| | | |

Symptoms

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.



Pg 4 History

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

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



BLADDER HEALTH QUIZ

Please respond yes or no.

1. Do you urinate more than every two hours in the daytime? _____
2. Do you urinate more than once after going to bed? _____
3. Do you have trouble making it to the toilet on time when you have an urge to go? _____
4. Do you strain to pass urine? _____
5. Do you rush to go to the toilet to empty your bladder? _____
6. Are you unable to stop the flow of urine when on the toilet? _____
7. Do you have an urge to go but when you get to the toilet very little urine comes out? _____
8. Do you lack the feeling that you need to go to the toilet? _____
9. Do you empty your bladder frequently, before you experience the urge to pass urine? _____
10. Do you have the feeling your bladder is still full after urinating? _____
11. Do you experience slow or hesitant urinary stream? _____
12. Do you have difficulty initiating the urine stream? _____
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) _____

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.