PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I 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 childbirth or 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, use of vaginal weights, 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.

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.

1 The purpose, risks, and benefits of this evaluation have been explained to me

2 I understand that I can terminate the procedure at any time.

3 I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.

4 I have the option of having a second person present in the room during the procedure and _____ choose _____ refuse this option.

Date _____ Patient Name: _____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature

NIH-Chronic Prostatitis Symptom Index (NIH-CPSI) (for males)

Center for Urologic and Pelvic Pain

Name: _____
Date: _____

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

	Yes	No
a. Area between rectum and testicles (perineum)	1	0
b. Testicles	1	0
c. Tip of the penis (not related to urination)	1	0
d. Below your waist, in your pubic or bladder area	1	0

2. In the last week, have you experienced:

	Yes	No
a. Pain or burning during urination?	1	0
b. Pain or discomfort during or after sexual climax (ejaculation)?	1	0

3. How often have you had pain or discomfort in any of these areas over the last week?

0 Never
1 Rarely
2 Sometimes
3 Often
4 Usually
5 Always

4 Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

0 1 2 3 4 5 6 7 8 9 10
NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

0 Not at all
1 Less than 1 time in 5
2 Less than half the time
3 About half the time
4 More than half the time
5 Almost always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

0 Not at all
1 Less than 1 time in 5
2 Less than half the time
3 About half the time
4 More than half the time
5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

0 None
1 Only a little
2 Some
3 A lot

8. How much did you think about your symptoms, over the last week?

0 None
1 Only a little
2 Some
3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

0 Delighted
1 Pleased
2 Mostly satisfied
3 Mixed (about equally satisfied and dissatisfied)
4 Mostly dissatisfied
5 Unhappy
6 Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index
Domains
Pain: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 3, and 4 =____
Urinary Symptom s: Total of items 5 and 6 =____
Quality of Life & Impact: Total of items 7, 8, and 9 =____

Adapted from Litwin et al. J Urol. 1999, 162 369-375.

Name: _____ Date: _____

Pain Disability Index

In order to determine how effective your treatment is, we need to know how much pain is interfering in your normal activities. For the 7 areas listed below, please circle the number on the scale which describes the level of disability you have experienced in each area OVER THE PAST WEEK. A score of "0" means no disability at all, and a score of "10" indicates that all of the activities which you would normally do have been totally disrupted or prevented by your pain over the past week. Circle "0" if a category does not apply to you.

Family/Home Responsibilities: This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g. yard work, house cleaning) and errands or favors for other family members (e.g. driving the children to school.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Social Activity: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as housewife or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Self-Care: This category includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed).

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Life-Support Activity: This category refers to basic life-supporting behaviors such as eating and sleeping.

0 1 2 3 4 5 6 7 8 9 10
No Disability *Mild* *Moderate* *Severe* *Total Disability*

Total Score: _____

Urogenital Distress Inventory (UDI-6 Short Form): UDI-6

1) Do you usually experience frequent urination? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

2) Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

3) Do you usually experience urine leakage related to coughing, sneezing, or laughing? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

4) Do you experience small amounts of urine leakage (that is, drops)? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

5) Do you experience difficulty emptying your bladder? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

6) Do you usually experience pain or discomfort in the lower abdomen or genital region? ☐ Yes ☐ No
   If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

   If yes, then is your pain relieved after emptying your bladder? ☐ Yes ☐ No

No= 0, Not at all= 1, Somewhat= 2, Moderately= 3, Quite a bit= 4
Add all scores and multiply by 6 then multiply by 25 for the scale score
Missing items are dealt with by using the mean from the answered items only
Higher score = higher disability
Also see scoring of PFDI-20.

Uebersax JS, Wyman JF, Shumaker SA, McClish DK, Fantl AJ. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and the urogenital distress inventory. *Neurourol and Urodynam* 1995;14:131-139.

Grade A rating for symptoms of UI for women
Donavan J, et al Symptom and quality of life assessment. In Incontinence vol 1 Basics and Evaluation eds Abrams P, Cardozo L, Khoury S, Wein A. Health Publications Ltd Paris France 2005.

Bladder symptoms

Do you lose urine when you: Cough/ sneeze/ laugh	Y	N	Lift/ exercise/ dance/ jump	Y	N
On the way to the bathroom	Y	N	Have a strong urge to urinate	Y	N
Hear running water	Y	N	Other _____	Y	N

Do you wet the bed	Y	N
Have burning/ pain with urination	Y	N
Difficulty starting a stream of urine	Y	N
Strain to empty your bladder	Y	N
Feel unable to empty bladder fully	Y	N
Have a falling out feeling	Y	N
Have pain with a full bladder	Y	N
Have an urgency of urination (a strong urge to urinate)	Y	N
Urinate more than 7 times/day	Y	N

Bowel symptoms

Strain to have a bowel movement	Y	N	Leak / stain feces	Y	N
Include fiber in your diet	Y	N	Have diarrhea often	Y	N
Take laxatives / enema regularly	Y	N	Leak gas by accident	Y	N
Have pain with bowel movement	Y	N			

Have a very strong urge to move your bowels Y N

How often do you move your bowels: _____ per day, week

Most common stool consistency
____ liquid ___ soft ___ firm ___ pellets ___ other _____

Thank you for taking the time to fill out this questionnaire.