Sports, Back & Pain Management Clinic

BODIES IN MOTION LIFELONG HEALTH

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, and/or pelvic pain conditions.

I understand that to evaluate my condition **it may be recommended, 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 of the vagina, penis, and/or rectum. The evaluation will assess skin condition, reflexes, muscle length, tone strength and endurance, scar mobility, and function of the pelvic floor region.

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

Treatment risks: I may experience an increase in my level of discomfort or pain, or an aggravation of my symptoms. The discomfit is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.
Potential benefits: 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.

Release of medical records: I authorize the release of my medical records to my physician or primary care provider 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.

Progress: I understand that my therapist will share with me their opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment. 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.

I have informed my therapist of any condition that would limit my ability to have an evaluation and/or treatment. I hereby request and consent to the evaluation and treatment to be provided by the therapists.

I understand that I have the option to a chaperone during any evaluation and/or treatment at any time. I understand that if my choice changes, I will inform my therapist. _____ Initial
I would like a chaperone. _____ Yes _____ No
I decline a chaperone. _____ Yes _____ No

Patient Name: _____ (Print)

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

2714 Osler Boulevard Bryan, TX 77802 (979) 776-2225 (Office) (979) 776-7945 (Fax) BVphysicaltherapy.com

Pelvic Floor Therapy Questionnaire

Patient name _____ **Date** _____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____ Number of vaginal deliveries _____

Birth weight of largest baby _____ Number of cesarean deliveries _____

Number of episiotomies _____ Date of last pap smear _____

Did you have any trouble healing after delivery Y N

Do you have a history of sexual abuse or trauma Y N

Are you having regular periods/ menstrual cycles Y N

Do you have frequent urinary tract infections Y N

Pain

Do you have pain with:

Sexual intercourse	Y	N
Pelvic exam	Y	N
Tampon use	Y	N
Back, leg, groin, abdominal pain	Y	N

Test results

Urodynamics test	Y	N	Results: _____
Cystoscope	Y	N	Results: _____
Urine test	Y	N	Results: _____
Bowel test	Y	N	Results: _____

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.

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: _____

Female NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

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 vagina (perineum)	1	0
b. Labia	1	0
c. Clitoris (not related to urination)	1	0
d. Below your waist in your pubic area	1	0
e. Below your waist in your rectal 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?	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 or 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, 1e, 2a, 2b, 3, and 4 =____
Urinary Symptoms 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

Urinary Distress Inventory (UDI-6) and Incontinence Impact Questionnaire (IIQ-7)

UDI-6

1. Do you experience, and, if so, how much are you bothered by frequent urination?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

2. Do you experience, and, if so, how much are you bothered by urine leakage related to the feeling of urgency?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

3. Do you experience, and, if so, how much are you bothered by urine leakage related to physical activity, coughing, or sneezing?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

4. Do you experience, and, if so, how much are you bothered by small amounts of urine leakage (drops)?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

5. Do you experience, and, if so, how much are you bothered by difficulty emptying your bladder?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

6. Do you experience, and, if so, how much are you bothered by pain or discomfort in the lower abdominal or genital area?

☐ **4***Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

IIQ-7

7. Has urine leakage affected your ability to do household chores (cooking, cleaning, laundry, etc)?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

8. Has urine leakage affected your physical recreation such as walking, swimming, or other exercise?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

9. Has urine leakage affected your entertainment activities (movies, concerts,etc.)?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

10. Has urine leakage affected your ability to travel by car or bus more than 30 minutes from home?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

11. Has urine leakage affected your participation in social activities outside your house?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

12. Has urine leakage affected your emotional health (nervousness, depression, etc.)?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

13. Has urine leakage affected your feeling frustrated?

☐ *Not at all* **0** ☐ *Slightly* **1** ☐ *Moderately* **3** ☐ *Greatly* **4**

14. Total Score for UDI-6=_____

15. Total Score for IIQ-7=_____