

**Folsom Physical Therapy  
& Training Center**

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

**IMPORTANT – READ IMMEDIATELY**

Your first appointment will take 45 to 90 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**
- 2. KEEPING A RECORD OF YOUR BLADDER FUNCTION**
- 3. DAILY VOIDING LOG.**

All these forms must be completed prior to your first appointment.

- **Begin the voiding log now.**
- Be sure to read the directions for **KEEPING A RECORD OF YOUR BLADDER FUNCTION** carefully so your log is as accurate as possible.
- 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 treatment.

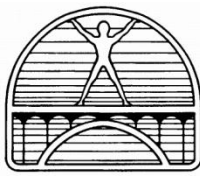
The office evaluation/treatment of your condition may include:

- 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 \_\_\_\_\_.



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**PELVIC FLOOR 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 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 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 penis 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 penile or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to the following: observation, palpation, penile 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 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.

**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 pay a cancellation fee of \$ 25.

**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.

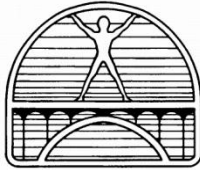
I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapist of Folsom Physical Therapy.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Please Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Signature of Parent or Guardian (If applicable)

\_\_\_\_\_  
Witness Signature



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**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.

\_\_\_\_\_

Date

\_\_\_\_\_

Patient Name (Please Print)

\_\_\_\_\_

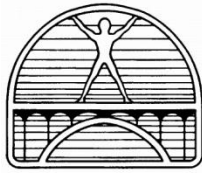
Patient Signature

\_\_\_\_\_

Signature of Parent or Guardian  
(If applicable)

\_\_\_\_\_

Therapist Signature



**Folsom Physical Therapy  
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Patient History**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

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  
Please describe and specify date \_\_\_\_\_  
\_\_\_\_\_

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

<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 (ie. - 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, please list _____	

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	Unexplained 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 /describe _____		

\_\_\_\_\_

**Pg 2 History**

**Name** \_\_\_\_\_

**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 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 \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Over the counter -vitamins etc**      **Start date**      **Reason for taking**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Pelvic Symptom Questionnaire

### 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.
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 \_\_\_\_\_

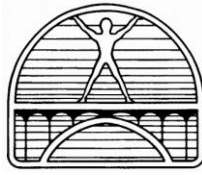
Skip questions if no leakage/incontinence

- |  |   |
|--|---|
| 9a. Bladder leakage - number of episodes<br><input type="checkbox"/> No leakage<br><input type="checkbox"/> Times per day<br><input type="checkbox"/> Times per week<br><input type="checkbox"/> Times per month<br><input type="checkbox"/> Only with physical exertion/cough | 9b. Bowel leakage - number of episodes<br><input type="checkbox"/> No leakage<br><input type="checkbox"/> Times per day<br><input type="checkbox"/> Times per week<br><input type="checkbox"/> Times per month<br><input type="checkbox"/> Only with exertion/strong urge |
|--|---|

- |   |  |
|---|--|
| 10a. On average, how much urine do you leak?<br><input type="checkbox"/> No leakage<br><input type="checkbox"/> Just a few drops<br><input type="checkbox"/> Wets underwear<br><input type="checkbox"/> Wets outerwear<br><input type="checkbox"/> Wets the floor | 10b. How much stool do you lose?<br><input type="checkbox"/> No leakage<br><input type="checkbox"/> Stool staining<br><input type="checkbox"/> Small amount in underwear<br><input type="checkbox"/> Complete emptying |
|---|--|

11. What form of protection do you wear? (Please complete only one)  
 None  
 Minimal protection (Tissue paper/paper towel/pantishields)  
 Moderate protection (absorbent product, maxipad)  
 Maximum protection (Specialty product/diaper)  
 Other \_\_\_\_\_

On average, how many pad/protection changes are required in 24 hours? \_\_\_\_\_ # of pads



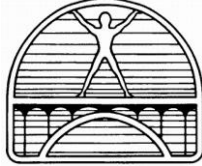
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**BLADDER HEALTH QUIZ**

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.



## **Folsom Physical Therapy & Training Center**

### *KEEPING A RECORD OF BLADDER FUNCTION*

The main purpose of a bladder log is to document how your bladder functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns. At first, the log is used as an evaluation tool. Later, it will be used to measure your progress on bladder retraining or leakage episodes. **Please complete a bladder log every day for \_\_\_\_\_ days and bring it with you to your appointment.**

Your log will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of the day exactly what happened in the morning.

### **INSTRUCTIONS**

#### ***Column 1 - Time of Day***

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold. Select the hour block that corresponds with the time of day you are recording information.

#### ***Column 2 - Type & Amount of Fluid & Food Intake***

- Record the type and amount of **fluid** you drank
- Record the type and amount of **food** you ate
- Record when you woke up for the day and the hour you went to sleep

#### **Column 3 - Amount Voided (Urinated): Three methods**

**Record the time of day and amount voided. Use the first method unless directed by your health care provider to directly measure or count urine amounts. Record a bowel movement with a BM at the appropriate time.**

1. Place an S, M, L, in the box at the corresponding time interval each time you urinate.  
S- SMALL= seemed like a small amount, or urinated “just in case”.  
M- MEDIUM= seemed like an 8 ounce measuring cup would run over.  
L- LARGE= seemed like the amount you urinate when you first wake up in the morning.
2. If you have difficulty gauging the amount of urine, you may record seconds by counting “one - one thousand” (this equals one second) while emptying your bladder. Record the total number of seconds it took you to void.
3. Measure urine amounts with a collection device. The best method is a collection “hat” that can be placed directly over the toilet. Ask your provider where to get one. Some people use 2-4 cup measuring containers, but it is sometimes difficult to catch the urine with these. Record the measured ounces of urine in the box at the corresponding time interval each time you urinate.

#### **Column 4 - Amount of Leakage**

**Record the amount of urine loss at the time it occurred.**

- S- SMALL= drop or two of urine
- M- MEDIUM= wet underwear
- L- LARGE= wet outerwear or floor

**Column 5 - Was Urge Present**

Describe the urge sensation you had as:

- 1- MILD= first sensation of need to go
- 2- MODERATE= stronger sensation or need
- 3- STRONG= need to get to toilet, move aside!

**Column 6 - Activity with Leakage**

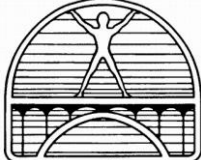
Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, bent over, lifted something or had a strong urge.

**Comments** – (at the bottom of the log table) Special problems and new or changes in medication are recorded here. If a pad change was needed, record the number used during the day at the bottom of the page.**Daily Voiding Log Sample**

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided in Ounces or S /M /L or seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am	Woke up at 6:45 am	L		3	
7:00 am	Coffee, bagel				
8:00 am			M		Fast walking
9:00 am	Apple	M		2	
10:00 am					
11:00 am		<u>S</u>		1	Key in the door
<b>NOON</b>	Tuna sandwich, milk, pear				
<b>1:00 pm</b>					
<b>2:00 pm</b>		M		2	
<b>3:00 pm</b>	Tea, cookies		S		Running water
<b>4:00 pm</b>					
<b>5:00 pm</b>					
<b>6:00 pm</b>	Chicken, corn pudding, salad, apple juice	<u>M</u>		3	
<b>7:00 pm</b>					
<b>8:00 pm</b>			S	3	
<b>9:00 pm</b>					
<b>10:00 pm</b>	To bed at 10:30	M		3	
<b>11:00 pm</b>					

Comments: \_\_\_\_\_

Number of pads: \_\_\_\_\_



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**DAILY VOIDING LOG**

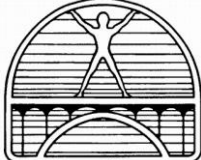
Name \_\_\_\_\_

Date \_\_\_\_\_

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided Ounces, S /M /L or Seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
<b>Midnight</b>					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
<b>Noon</b>					
<b>1:00 pm</b>					
<b>2:00 pm</b>					
<b>3:00 pm</b>					
<b>4:00 pm</b>					
<b>5:00 pm</b>					
<b>6:00 pm</b>					
<b>7:00 pm</b>					
<b>8:00 pm</b>					
<b>9:00 pm</b>					
<b>10:00 pm</b>					
<b>11:00 pm</b>					

Comments \_\_\_\_\_

Number of pads used today \_\_\_\_\_



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**DAILY VOIDING LOG**

Name \_\_\_\_\_

Date \_\_\_\_\_

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided Ounces, S /M /L or Seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
<b>Midnight</b>					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
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11:00 am					
<b>Noon</b>					
<b>1:00 pm</b>					
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<b>6:00 pm</b>					
<b>7:00 pm</b>					
<b>8:00 pm</b>					
<b>9:00 pm</b>					
<b>10:00 pm</b>					
<b>11:00 pm</b>					

Comments \_\_\_\_\_

Number of pads used today \_\_\_\_\_