



Medically-Based Fitness

## PELVIC FOOR 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 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.

**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 \$

**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 therapists and therapy assistants and technicians of

Date \_\_\_\_\_

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

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

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

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



Medically-Based Fitness  
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 _____		

\_\_\_\_\_

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 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 # _____	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 _____	Y/N	Erectile dysfunction
Y/N	Prostate disorders	Y/N	Painful ejaculation
Y/N	Shy bladder		
Y/N	Pelvic pain		
Y/N	Other /describe _____		

Medications - pills, injection, patch

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

### 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
- 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/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