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

BEYOND KEGELS ASSESSMENT-HISTORY

Name _____ Date _____

Sex _____ Age _____ BD _____ Physician _____

Chief Complaint/Problem

Describe, state onset date, precipitating event, pattern of increased/decreased symptoms, previous treatment

_____

_____

_____

Symptom Picture Symptom Duration	yes	no
Symptoms chronic (>3months)	☐	☐
Symptoms acute	☐	☐
Describe:		

Daytime Toileting

Toileting every 4 hours	☐	☐
Toileting every 2-3 hours	☐	☐
Toileting every hour	☐	☐
Toileting every 30-59 min	☐	☐
Other	☐	☐
Describe:		

Nighttime Toileting

Rarely/never	☐	☐
Once a night	☐	☐
Two to three times/night	☐	☐
More than three times/night	☐	☐
Other	☐	☐
Describe:		

Leaking Urine Nighttime

Rarely/never	☐	☐
One to two nights/week	☐	☐
Three to four nights/week	☐	☐
More than four nights/week	☐	☐
Other	☐	☐
Describe:		

Leaking Urine Daytime:

Once every two weeks	☐	☐
Once a week	☐	☐
Two to three days/week	☐	☐
Four or more days/week	☐	☐
Once a day	☐	☐
Multiple times daily	☐	☐
Constantly all day	☐	☐
Other	☐	☐
Describe:		
Morning primarily	☐	☐
Afternoon/Evening primarily	☐	☐
No pattern	☐	☐
Describe:		

Amount of Urine Leaked

A few drops	☐	☐
A small gush or spurt	☐	☐
A large leak	☐	☐
Varies	☐	☐
Other	☐	☐
Describe:		

Protection Used (If used)

Adult continence products (#/day)	☐	☐
Sanitary pads (#/day)	☐	☐
Pantiliner (#/day)	☐	☐
Other	☐	☐
Describe:		

Activities Related to Leaking

Coughing/sneezing	☐	☐
Laughing	☐	☐
Walking	☐	☐
Position change	☐	☐
Supine to sit	☐	☐
Sit to stand	☐	☐
Bending/lifting	☐	☐
Running/jumping	☐	☐
Aerobics	☐	☐
Water running/shower	☐	☐
Feeling cold	☐	☐
During intercourse	☐	☐
Before/during menstruation	☐	☐
Key in the door	☐	☐
When constipated	☐	☐
Other	☐	☐
Describe:		

Perception of Need to Urinate

No perception of bladder fullness	☐	☐
Leaks immediately after awareness	☐	☐
Leaks 1-2 min. after awareness	☐	☐
Toileting awareness without problem	☐	☐
Other	☐	☐
Describe:		

Observations During Urination

Difficulty initiating stream	☐	☐
Weak/slow urine stream	☐	☐
Dribbling after stream ends	☐	☐
Pain during urination	☐	☐
Burning during urination	☐	☐
Blood in urine	☐	☐
Abnormal color	☐	☐
Abnormal odor	☐	☐
Other	☐	☐
Describe:		

Bowel Patterns

Experience frequent diarrhea	☐	☐
Experience frequent constipation	☐	☐
Bowel movements daily	☐	☐
Bowel movement every 2-3 days	☐	☐
Bowel movement every 4-5 days	☐	☐
Use laxatives	☐	☐
Other	☐	☐

Describe:

Fluid Intake

Caffeine consumption(#cups/day)	☐	☐
Alcohol intake(#drinks/day)	☐	☐
Fluid consumption <6-8 glasses/day	☐	☐

Describe pattern of fluid intake:

Medication Intake

Over the counter medication	☐	☐
Prescription medication	☐	☐
Diuretics	☐	☐

List:

List Surgeries

Bowel/Bladder	☐	☐
Reproductive Organs	☐	☐
Spine/Back	☐	☐
Brain	☐	☐
Other	☐	☐

Describe:

Medical History

Neurological	☐	☐
CNS conditions	☐	☐
PNS conditions	☐	☐
Musculoskeletal conditions	☐	☐
Urinary tract infections	☐	☐
Abdominal/pelvic pain	☐	☐
Other	☐	☐

Describe:

Exercise History

Daily	☐	☐
5-6 times weekly	☐	☐
3-4 times/week	☐	☐
1-2 times/weekly	☐	☐
None	☐	☐
Other	☐	☐

Describe type and duration:

Social/Psychological History

Has leaking affected your lifestyle	☐	☐
Childhood nighttime bedwetting	☐	☐
Pertinent family history- leaking	☐	☐
Abuse/injury	☐	☐
Other	☐	☐

Describe:

Activities of Daily Living Limitations
Needs assistance to:

Transport self to toilet	☐	☐
Transfer onto toilet	☐	☐
Manage clothing	☐	☐

Describe:

Women Only
Pregnancy [#]

Vaginal deliveries(#)	☐	☐
Cesarean deliveries(#)	☐	☐
Miscarriages/abortions(#)	☐	☐
Episiotomies(#)	☐	☐
Leaking in pregnancy/postpartum	☐	☐
Complications in pregnancy	☐	☐
Complications in labor/delivery	☐	☐
Complications in postpartum	☐	☐
Other	☐	☐

Describe:

Menstruation[age]

Change in urine control	☐	☐
Change in weight	☐	☐
Change in exercise habits	☐	☐
Change in over all health	☐	☐
Change in pain complaints	☐	☐
Other	☐	☐

Describe:

Menopause [date/age]

Change in urine control	☐	☐
Change in weight	☐	☐
Change in exercise habits	☐	☐
Change in over all health	☐	☐
Change in pain complaints	☐	☐
Other	☐	☐

Describe:

Problem List

list the pertinent items checked in the yes column

1.

2.

3.

4.

5.

6.

CARE CONNECTIONS

PELVIC FLOOR WORKSHEET

NAME _____ DATE _____

TIME _____ AM/PM ☐ Initial Visit ☐ Discharge Visit

CONDITION (CHECK ALL THAT APPLY)

☐ (A) Bladder incontinence
☐ (B) Urinary urgency/frequency
☐ (C) Bowel incontinence
☐ (D) Fecal urgency
☐ (E) Pelvic/perineal pain
☐ (F) Other

ACUITY *(Answer on initial visit.)*

How long ago did onset of symptoms occur? _____

FUNCTION

To what degree does your condition interfere with your participation in the following activities: (if you have bowel or bladder problems, rate interference when you are NOT using a pad or leakage protection).

	Never Interferes	10-20% of the time	30-40% of the time	50-60% of the time	70-80% of the time	Always Interferes
1. Household Activities	☐	☐	☐	☐	☐	☐
2. Physical Activity/Exercise	☐	☐	☐	☐	☐	☐
3. Intimate Relationships	☐	☐	☐	☐	☐	☐
4. Sitting through long events (more than 3 hours)	☐	☐	☐	☐	☐	☐
5. Work Activities	☐	☐	☐	☐	☐	☐
6. Activities without bathroom access	☐	☐	☐	☐	☐	☐
7. Travel	☐	☐	☐	☐	☐	☐
8. Sleep (# times/night your sleep is interrupted)	☐0×	☐1×	☐2×	☐3×	☐4×	☐5+×
9. Number absorbent products used per day to manage your condition	☐0×	☐1×	☐2×	☐3×	☐4×	☐5+×

10. PLEASE INDICATE TYPE OF PROTECTION USED

☐ (A) none
☐ (B) tissue/paper towels
☐ (C) panty liner
☐ (D) medium flow pad
☐ (E) heavy flow pad
☐ (F) specialty pad/protective garment

11. Number of bowel/urine leakage accidents per 24 hours? _____

12. Frequency of daytime urination? _____

13. Frequency of nighttime urination? _____

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain ——— Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)