



Tigard Physical Therapy & Massage

Lynne Marshall-Brook, MSPT, OCS, LMT
18019 SW Lower Boones Ferry Road
Tigard, OR 97224

(P) 503-753-1537

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**CONSENT FOR EVALUATION AND TREATMENT OF
PELVIC FLOOR DYSFUNCTION**

I acknowledge and understand that I have been referred to Lynne Marshall-Brook, MS PT, OCS, LMT 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 vulvar or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform internal pelvic floor muscle examination. This examination is performed by observing and palpating the perineal region included 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 and/or treatment could potentially elicit pain or discomfort.

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/manipulation and educational instruction.

I understand that no guarantees have been or can be provided regarding the success of therapy. I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and staff of Tigard Physical Therapy, Inc.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

Signature of Parent/Guardian (if applicable): _____

Witness Signature: _____



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PELVIC HEALTH SCREENING QUESTIONNAIRE - Men

Name: _____ Date: _____ Age: _____

Date of last prostate exam: _____ Date of urinalysis: _____

Other tests: _____

Circle any/all of the specific problems or conditions you now have or have ever had. Explain all yes responses below and include the date the problem began.

Surgical History

Y/N Surgery for your back/spine

Y/N Surgery for your bladder

Y/N Surgery for your brain

Y/N Surgery for your male organs

Y/N Surgery for your abdominal organs

List surgeries/dates: _____

Sex/Genital History

Y/N Difficulty getting an erection

Y/N Pelvic pain

Y/N Difficulty maintaining an erection

Y/N Painful penis/testicles

Y/N Painful erection

Y/N Pain during sex

Y/N Painful ejaculation

Y/N

Other: _____

Bladder/Bowel

Y/N Trouble initiating urine stream

Y/N Trouble emptying bladder completely

Y/N Childhood bladder problems

Y/N Recurrent bladder infections

Y/N Constant dribbling of urine

Y/N Constipation/straining for movement

Y/N Blood in urine

Y/N Trouble holding back gas/feces

Y/N Urinary hesitancy/slow stream

Y/N Trouble feeling bowel urge/fullness

Y/N Trouble feeling bladder urge/fullness

Y/N Difficulty stopping the urine stream

Y/N Dribbling after urination

Y/N Straining or pushing to empty bladder

Other: _____

Explain all yes responses: _____

Medication

Start date

Reason for taking



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PELVIC SYMPTOM QUESTIONNAIRE PAGE 1

Name: _____ Date: _____ Age: _____

1) Describe your main problem: _____

2) When did your pelvic floor/bowel/bladder 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 the incident and specify the date: _____

4) Since that time is it: staying the same _____, getting worse _____, or getting better _____?

Why or how? _____

5) Frequency of urination: awake hours _____ times per day, sleep hours _____ times per night.

6) 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.

7) The usual amount of urine passed is: small _____, medium _____, or large _____.

8) Frequency of bowel movements: _____ times per day, _____ times per week, or _____.

9) 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.

10) Average fluid intake (one glass is 8oz or one cup) _____ glasses per day.

Of this total, how many glasses are caffeinated? _____ glasses per day.

11) Rate a feeling of organ "falling out" or pelvic heaviness/pressure:

___ None present

___ Times per month: _____

___ With standing for _____ minutes or _____ hours

___ With exertion or straining

___ Other: _____

12a) Bladder leakage – number of episodes

___ No leakage

___ Times per day

___ Times per week

___ Times per month

___ Only with physical exertion/cough

12b) Bowel leakage – number of episodes

___ No leakage

___ Times per day

___ Times per week

___ Times per month

___ Only with exertion



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PELVIC SYMPTOM QUESTIONNAIRE PAGE 2

13a) On average, how much urine do you leak?

- No leakage
- Just a few drops
- Wets underwear
- Wets outerwear
- Wets the floor

13b) How much stool do you lose?

- No leakage
- Stool staining
- Small amount in underwear
- Complete emptying

14) What form of protection do you use? (Please only select only one)

- None
- Minimal protection (tissue paper/paper towel/panty liners)
- Moderate protection (absorbent product, maxi pad)
- Maximum protection (specialty product/diaper)
- Other: _____

15) On the average, how many pad changes are required in 24 hours? _____ # of pads.

16) What activities or events cause your symptoms? Check all that apply.

- Strong urge to go
- Walking to the toilet
- With cough/sneeze/laugh/yell
- Light activity (walking, light housework)
- Other, please list: _____
- Changing positions (example: sit to stand)
- No activity changes the problem
- Vigorous activity or exercise (running, jumping)
- Sexual activity

17) How has your lifestyle/quality of life been altered or changed because of this problem? Please respond to all that apply.

Social activities (exclude physical activities), specify: _____

Diet/Fluid intake, specify: _____

Physical activity, specify: _____

18) Rate your feelings as to the severity of this problem from 0-10 with 0 being no problem and 10 being the worst: _____



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CONFIDENTIAL PATIENT QUESTIONNAIRE – Pelvic Health

Name: _____ Date: _____ Age: _____

Pelvic floor dysfunction can be very distressing. Whether your symptoms are urinary incontinence, fecal incontinence, pelvic floor pain or painful intercourse, these issues are not easily discussed openly with family, friends or doctors.

In order to fully understand the scope of your individual diagnosis, there are some very important questions we need answered. Please feel free to be brief with your answers. If your therapist needs you to expand upon your answers, she will ask you privately. All information provided will be held in the strictest confidence, per HIPAA regulations.

1) Are you currently sexually active? Yes No

If no, have you been sexually active in the past? Yes No

2) Does your sexual partner (past or present) include any anal entry activities? Yes No

3) Do you have any communicable diseases? Yes No

If yes, please describe: _____

4) Has there been any sexual abuse in your past? Yes No

Thank you for your honest answers. They will aide us in your care and allow us to be sensitive to your individual needs.