**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 - Women

Name: _____ Date: _____ Age: _____

Date of last pelvic exam: _____ Date of urinalysis: _____
Other tests (types and dates): _____

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 (list below)
Y/N Surgery for your brain
Y/N Surgery for your abdominal organs (list below)
Y/N Surgery for your bladder
Y/N Surgery for your female organs (list below)
Other: _____

Ob/Gyn History (females only)

Y/N Vaginal deliveries #_____
Y/N Episiotomy #_____ Perineal Tearing #_____
Y/N Abdominal Births (C-section) #_____
Y/N Difficult childbirth #_____
Y/N Abortions #_____
Y/N Miscarriages #_____
Y/N Birth Control Method_____
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when? _____
Y/N Painful vaginal penetration
Y/N Pelvic pain
Y/N Prolapse/organ falling out/pelvic pressure
Other: _____

Bladder/Bowel

Y/N Trouble initiating urine stream
Y/N Childhood bladder problems
Y/N Constant dribbling of urine
Y/N Blood in urine
Y/N Urinary hesitancy/slow stream
Y/N Trouble feeling bladder urge/fullness
Y/N Dribbling after urination
Y/N Trouble emptying bladder completely
Y/N Recurrent bladder infections
Y/N Constipation/straining for movement
Y/N Trouble holding back gas/feces
Y/N Trouble feeling bowel urge/fullness
Y/N Difficulty stopping the urine stream
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: _____

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, specify if related to activity or your period: _____
___ 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)
___ Changing positions (example: sit to stand)
___ No activity changes the problem
___ Vigorous activity or exercise (running, jumping)
___ Sexual activity
___ Other, please list: _____

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.*