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|  **Tigard Physical Therapy & Massage** 12700 SW Pacific Hwy Tigard, OR 97223 www.tigardphysicaltherapy.com | **(P)** 503-753-1537 **(F)** 503-573-8004**(E)** tigardpt@gmail.com |

**CONSENT FOR EVALUATION AND TREATMENT OF**

**PELVIC FLOOR DYSFUNCTION**

 I acknowledge and understand that I have been referred to Lynne Marshall-Brook, MS PT, LMT or Miranda Paasche, DPT 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medication Start date Reason for taking

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PELVIC SYMPTOM QUESTIONNAIRE PAGE 1**

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

1) Describe your main problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 12b) Bowel leakage – number of episodes

 \_\_\_ No leakage \_\_\_ No leakage

 \_\_\_ Times per day \_\_\_ Times per day

 \_\_\_ Times per week \_\_\_ Times per week

 \_\_\_ Times per month \_\_\_ Times per month

 \_\_\_ Only with physical exertion/cough \_\_\_ Only with exertion

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**PELVIC SYMPTOM QUESTIONNAIRE PAGE 2**

13a) On average, how much urine do you leak? 13b) How much stool do you lose?

\_\_\_ No leakage \_\_\_ No leakage

\_\_\_ Just a few drops \_\_\_ Stool staining

\_\_\_ Wets underwear \_\_\_ Small amount in underwear

\_\_\_ Wets outerwear \_\_\_ Complete emptying

\_\_\_ Wets the floor

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 \_\_\_ Changing positions (example: sit to stand)

\_\_\_ Walking to the toilet \_\_\_ No activity changes the problem

\_\_\_ With cough/sneeze/laugh/yell \_\_\_ Vigorous activity or exercise (running, jumping)

\_\_\_ Light activity (walking, light housework) \_\_\_ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_Physical activity, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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.*