Pelvic Floor Therapy Questionnaire

Patient name _____ Date _____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____ Number of vaginal deliveries _____
Birth weight of largest baby _____ Number of cesarean deliveries _____
Number of episiotomies _____ Date of last pap smear _____

Did you have any trouble healing after delivery: Y N
Do you have a history of sexual abuse or trauma: Y N
Are you having regular periods/ menstrual cycles: Y N
Do you have frequent urinary tract infections: Y N

Pain

Do you have pain with:
Sexual intercourse: Y N
Pelvic exam: Y N
Tampon use: Y N
Back, leg, groin, abdominal pain: Y N

Test results

Urodynamics test: Y N
Results: _____
Cystoscope: Y N
Results: _____
Urine test: Y N
Results: _____
Bowel test: Y N
Results: _____

Bladder symptoms:
Do you lose urine when you:
Cough/ sneeze/ laugh Y N
Lift/ exercise/ dance/ jump Y N
On the way to the bathroom Y N
Have a strong urge to urinate Y N
Hear running water Y N
Other _____ Y N
Do you wet the bed Y N
Have burning/ pain with urination Y N
Difficulty starting a stream of urine Y N
Strain to empty your bladder Y N
Feel unable to empty bladder fully Y N
Have a falling out feeling Y N
Have pain with a full bladder Y N
Have an urgency of urination (a strong urge to urinate) Y N
Urinate more than 8 times/day Y N

Bowel symptoms
Strain to have a bowel movement Y N
Leak / stain feces Y N
Include fiber in your diet Y N
Have diarrhea often Y N
Take laxatives / enema regularly Y N
Leak gas by accident Y N
Have pain with bowel movement Y N
Have a very strong urge to move your bowels Y N
How often do you move your bowels: _____ per day, week
Most common stool consistency ____ liquid ___ soft ___ firm ___ pellets ___
other _____

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 to have a second person OR _____ refuse this option.

Date:_____
Patient Name: _____
Patient Signature Signature OR Parent or Guardian (if applicable): _____