PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

Informed Consent For Treatment:

The term “informed consent” means that the potential risk, benefits, and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also 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. The internal examination is performed by observing and/or palpating the perineal region including inside 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. The 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.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

Potential Benefits: May include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider. Release of Medical Records: I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Cooperation with Treatment: 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.

Cancellation Policy: I understand that if I need to cancel I should call at least 24 hours ahead of the scheduled appointment time. If I am more than 10 minutes late or cancel less than 3 hours in advance, it will be classified as a “No Show”. If I have two No Show sessions then I will be unable to schedule future appointments at this clinic.

No Warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

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 therapy assistants and technicians of Longivew Physical and Sports Therapy.

Date: ___________________ Patient’s Name:____
(Please Print)

____ Patient Signature

____ Signature of Parent or Guardian (if applicable)

____ Witness Signature

PELVIC HEALTH PHYSICAL THERAPY INTAKE FORM

Name _________________ Preferred Name _______________ Age ____ Weight ______ Height ______

Briefly describe the problem that brought you in today, how it began, and when. ____________________
____
____

Check the activities/events that cause or aggravate your symptoms. Check all that apply OR
☐ *no activity affects the problem*

☐ Sitting more than ____ minutes ☐ Light activity (light housework) ☐ With nervousness/anxiety
☐ Walking more than ____ minutes ☐ Changing positions (sit to stand) ☐ With lifting/bending
☐ Standing more than ____ minutes ☐ With coughing/sneezing/straining ☐ With laughing/yelling
☐ Sexual intercourse ☐ With trigger - running water/key in door ☐ Vigorous activity (run/jump/lifting)
☐ With cold weather ☐ Other activities____

What, if anything, relieves your symptoms? ____

If pain is present, please rate on a scale of 0 – 10. 0 is no pain. 10 is worst pain you can imagine. _______

Where did your pain begin? __________________ Since it started, pain is ☐ Worse ☐ Better ☐ Same

Current level of pain ___ Worst level of pain in last three days __ Best level of pain in last three days ___

My pain is: ☐ Intermittent ☐ Constant ☐ Aching ☐ Shooting ☐ Sharp ☐ Cramping ☐ Throbbing
☐ Dull ☐ Squeezing ☐ Stabbing ☐ Sore ☐ Burning ☐ Other _______________________________

What makes the pain worse?____

What makes the pain better? ____

Have you had similar problems/symptoms in the past? ☐ Yes ☐ No When? _______________________

Was your first episode of the problem related to a specific incident? ☐ Yes ☐ No If yes, Explain________
____

Since that time, the problem is ☐ Staying the same ☐ Getting worse ☐ Getting better

Why or how?____

Describe previous treatment/exercises. ____
____

Please indicate what you would like to achieve through therapy. ________________________________
____

Please indicate any concerns you have about receiving therapy. _______________________________
____

Are there any beliefs, values, rules, or customs that the therapist needs to consider when treating you?
____

PELVIC HEALTH INTAKE FORM 2

Month/Year of last physical exam ____/____ Tests performed ______________________________
Indicate dates of exams with specialists (urologists, gastroenterologists, ob/gyns) _________________
How would you rate your current overall health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
Rate your current level of stress. ☐ Low ☐ Medium ☐ High   Current psychiatric therapy ☐ Yes ☐ No
Occupation _______________ Hours/week ___ Activity/Exercise ___ Times/week Type______________

Consume Alcohol ☐Yes ☐No __ alcoholic beverages/week Cigarette smoking ☐Yes ☐No ☐In the past

Please check the corresponding box to indicate if you have or have had any of the following conditions.

☐ Fibromyalgia
☐ Lupus
☐ Diabetes
☐ Lyme disease
☐ Obesity
☐ Thyroid disorder
☐ Low back pain
☐ Sacroiliac disease
☐ TMJ/neck pain
☐ Rheumatoid arthritis
☐ Osteoarthritis
☐ Osteoporosis/osteopenia
☐ Scoliosis
☐ Headaches/migraines
☐ Chronic fatigue syndrome
☐ Joint replacement________
☐ Fractures - site __________
☐ Latex sensitivity
☐ Multiple sclerosis
☐ TIA/CVA/stroke
☐ Seizures/epilepsy
☐ Traumatic brain/head Injury
☐ Anemia
☐ Alcohol/substance abuse
☐ Psychiatric disorder
☐ Anxiety/depression
☐ Postpartum depression
☐ Anorexia/bulimia
☐ Hepatitis
☐ HIV/AIDS
☐ Sexually transmitted disease
☐ Hernia
☐ Bowel/bladder dysfunction
☐ Painful bladder
☐ Current active infection/UTI
☐ Childhood bladder problems
☐ Kidney disease
☐ Alzheimer's disease/dementia
☐ High or low blood pressure
☐ Irritable bowel syndrome
☐ Post traumatic stress disorder
☐ Acid reflux/ulcers
☐ Raynaud's (cold hands/feet)
☐ Lymphedema or extremity swelling
☐ Heart disease
☐ Chronic cough/bronchitis/emphysema
☐ Asthma/breathing disorders
☐ Hearing loss/problems
☐ Vision/eye problems
☐ Currently pregnant/# weeks _____
☐ Physical abuse/trauma
☐ Sexual abuse/trauma
☐ Cancer – type _________________
☐ Other ________________________

Indicate surgical history below by checking all that apply. ☐ Recent surgery? Date/type:______________
☐ Back/Spine ☐ Hysterectomy ☐ Bones/Joints ☐ Mastectomy ☐ Gallbladder/Appendix removed
☐ Brain ☐ Bladder/Prostate ☐ Abdominal organs ☐ Hernia repair ☐ other______________________

Female – *Indicate history by checking all that apply.* ☐ Painful incision/scars? Location _____________
☐ # Pregnancies _____ ☐ # of Vaginal deliveries _____ ☐ # of C-sections _____ ☐ Difficult childbirth
☐# of Episiotomies ____ ☐ Vaginal dryness ☐ Painful vaginal penetration ☐ Painful periods
☐ Pelvic pain ☐ Endometriosis ☐ Polycystic Ovarian Syndrome ☐ Prolapse or organ falling out
☐ Pudendal Neuralgia ☐ Menopause: Date began _________ ☐other __________________________

Male – *Indicate history by checking all that apply.* ☐ Painful incision/scars? Location _______________
☐ Prostate disorders ☐ Painful ejaculation ☐ Pelvic pain ☐ Shy bladder ☐ Erectile dysfunction
☐ Other ____

List (or provide a list of) all current prescription and over the counter medications/supplements, including start date, dosage, frequency, and reason for taking. ☐ Currently taking antibiotics ________________

____

List all allergies that you may have.

____

PELVIC HEALTH INTAKE FORM 3

BLADDER AND BOWEL SYMPTOMS

Please check any of the pelvic symptoms you are experiencing.

☐ Trouble initiating urine stream
☐ Urinary intermittent/slow stream
☐ Difficulty stopping urine stream
☐ Trouble emptying bladder
☐ Trouble emptying bowel
☐ Pain with bowel movements
☐ Trouble feeling bladder urge/fullness
☐ Dribbling after urination
☐ Constant urine leakage
☐ Blood in urine
☐ Completely painful urination
☐ Straining/pushing to empty bladder
☐ Trouble holding back gas/feces
☐ Current laxative use
☐ Recurrent bladder infections
☐ Constipation/straining
☐ Frequent abdominal bloating
☐ Other ___________________

Frequency of urination: **Awake hours** _____ times per day **Sleep hours** _____ times per night
When you have a normal urge to urinate, how long are you able to delay before you have to use the toilet? _____ minutes _____ hours or ☐ I can't wait
The usual amount of urine passed is: ☐ Small ☐ Medium ☐ Large

Frequency of bowel movements _____ times per day _____ times per week other ___________________
When you have an urge to have a bowel movement, how long are you able to delay before you have to use the toilet? _____ minutes _____ hours or ☐ I can't wait
If constipation is present, please describe management techniques ________________________________

Do you have the feeling of organ "falling out"/prolapse or pelvic heaviness/pressure? ☐ Yes ☐ No
☐ With standing for ____ minutes or ____ hours ☐ With exertion/straining ☐ Other_________________
Indicate average fluid intake ___ 8 oz cups/day Indicate how many of these cups are caffeinated ____

If not experiencing leakage or incontinence of bladder or bowel, please skip this section.
I am experiencing bladder leakage. ☐ Yes ☐ No ☐ Only with physical exertion/cough
Number of episodes ____ Times/day ____ Times/week _____ Times/month
On average, how much urine do you leak?
☐ Few drops ☐ Wets underwear ☐ Wets outerwear ☐ Wets floor

I am experiencing bowel leakage. ☐ Yes ☐ No ☐ Only with exertion/strong urge
Number of episodes ____ Times/day ____ Times/week _____ Times/month

On average, how much stool do you lose?
☐ Stool staining ☐ Small amount in underwear ☐ Complete emptying

Indicate what form of protection you wear.
☐ None ☐ Minimal (tissue/paper towel/panty shield) ☐ Moderate (absorbent product/maxipad)
☐ Maximum (specialty product/diaper)
Indicate, on average, how many pad/protection changes are required in 24 hours. _____ # of pads

Date: _________________ Patient Signature:____

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