



**PHYSICAL THERAPY**  
**& Sports Performance**

381-A Lucy Drive • Harrisonburg, VA 22801 • (540) 434-1200 • Fax: (540) 434-1203  
54 Franklin Street • Village Square Plaza • Weyers Cave, VA 24486 • (540) 234-8800 • Fax (540) 234-8939

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## **INFORMATION ON TREATMENT FOR PELVIC FLOOR DYSFUNCTION AND BLADDER/BOWEL PROBLEMS**

### **IMPORTANT – READ IMMEDIATELY**

Your first appointment will take 60 to 90 minutes so please plan your time appropriately. Arrive at least 15 minutes early to complete necessary paperwork.

Your appointment is scheduled for \_\_\_\_\_ a.m./p.m. on \_\_\_\_\_

Enclosed please find:

- 1. HISTORY AND SCREENING QUESTIONNAIRES**
- 2. KEEPING A RECORD OF YOUR BLADDER FUNCTION**
- 3. DAILY VOIDING LOG.**
- 4. CONSENT FOR EVALUATION AND TREATMENT**

All these forms must be completed prior to your first appointment.

- **Begin the voiding log now.**
- Be sure to read the directions for **KEEPING A RECORD OF YOUR BLADDER FUNCTION** carefully so your log is as accurate as possible.
- Incomplete information may delay insurance processing and authorization for subsequent treatment.
- Prior to your first appointment we recommend you check with your insurance company regarding coverage for treatment.

The office evaluation/treatment of your condition may include:

- Review of your history.
- Measurement of your pelvic floor muscle function with biofeedback equipment. These instruments record your muscle activity and help evaluate and treat your pelvic floor muscles.
- Musculoskeletal and pelvic floor muscle exam.
- Exercise instruction for pelvic floor and other muscle groups as indicated.

Return visits for therapy will be scheduled at regular intervals to measure your progress and modify your exercise program as needed. These appointments are important in order to progress your treatment program.

Please feel free to invite someone to accompany you to your appointments if doing so will make you feel more comfortable.

If you have any questions, please telephone **540-434-1200**.



PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment:

The term "informed consent" means that the potential risks, 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. 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.

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: I may experience 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: If you are unable to keep your appointment we would like to be notified 24 hours before your scheduled appointment. If we do not receive a notification of your cancellation prior to your appointment, a \$35.00 "No Show/ No Call" charge will be added to your account and due in full at the time of your next scheduled appointment. This charge is not covered by any insurance.

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 and 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 Valerie Stapel.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

(Please Print)

Signature of Parent or Guardian (If applicable)

Patient Signature

Witness Signature

# PELVIC FLOOR SUBJECTIVE

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
Diagnosis \_\_\_\_\_ Physician \_\_\_\_\_  
Occupation/Primary activities \_\_\_\_\_ Phone # \_\_\_\_\_

Please describe your main complaint and symptom progression:

\_\_\_\_\_  
\_\_\_\_\_  
When did your first episode of (circle) incontinence or pain begin? \_\_\_\_\_

If you have incontinence, did the onset begin after:  childbirth  prostatectomy  
 surgery (please specify) \_\_\_\_\_  other (please specify) \_\_\_\_\_

## PAIN HISTORY

Do you have pain?  Yes  No (if no pain please skip to Incontinence History – page 2)  
Circle your current pain level on a 0-10 scale. 0 is no pain, 10 is the worst pain you can imagine:  
0 1 2 3 4 5 6 7 8 9 10

Are the pain symptoms:  staying the same  getting worse  getting better

Please describe the pain (check appropriate choices):  burning  aching  sharp  dull  
 throbbing  pins and needles  constant  intermittent

Where is your pain? \_\_\_\_\_

Is it worse on the  left or  right?

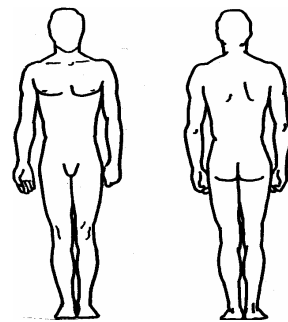
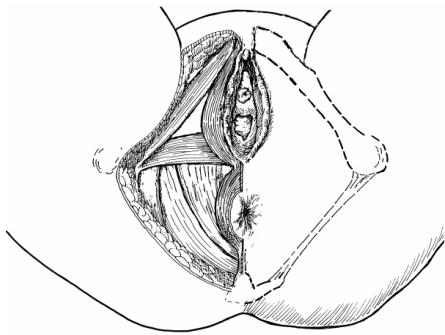
What makes it worse? \_\_\_\_\_

What relieves the pain? \_\_\_\_\_

Do you have pain elsewhere?  No  Yes (please specify) \_\_\_\_\_

Have you ever been physically or sexually abused?  No  Yes

Please indicate the area(s) of pain on the drawing below:



What medical work ups or screenings have you undergone for this condition? \_\_\_\_\_

What treatments have you tried for this condition? (check all that apply)

- surgery (please specify) \_\_\_\_\_
- medication(s) (please specify) \_\_\_\_\_
- exercise(s) (please specify date initiated) \_\_\_\_\_

What is your goal for physical therapy? \_\_\_\_\_

# BLADDER HISTORY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## INCONTINENCE HISTORY: please answer the questions to the best of your ability

1. Please describe your frequency of urination:  
During awake hours: \_\_\_\_\_ times per day      During sleep hours: \_\_\_\_\_ times per day
2. When you have a normal urge to urinate, how long can you delay before you must go to the toilet?  
 minutes       hours       not at all
3. The usual amount of urine you pass is:  small  medium       large
4. Your average fluid intake (one glass is equal to 8 oz or 1 cup): \_\_\_\_\_ glasses per day
5. Of this total fluid intake, how many glasses are caffeinated? \_\_\_\_\_ glasses per day
6. Please describe your frequency of bowel movements:  
\_\_\_\_\_ times per day      \_\_\_\_\_ times per week
7. When you have an urge to have a bowel movement, how long can you delay before you must go to the toilet?  
 minutes       hours       not at all
8. Please rate your feeling of organ "falling out" or pelvic heaviness/pressure:  
 none  
 at times in the month (please specify if related to activity or your period)  
 with standing (for \_\_\_\_\_ minutes or \_\_\_\_\_ hours)  
 with exertion or straining  
 other: \_\_\_\_\_

### Skip to Question 13 if you do not experience leakage.

9. Bladder leakage; number of episodes:  
 no leakage  
 \_\_\_\_\_ times per day  
 \_\_\_\_\_ times per week  
 \_\_\_\_\_ times per month  
 only with physical exertion or cough  
On average, how much urine do you leak?  
 no leakage  
 just a few drops  
 wets underwear  
 wets outerwear  
 wets the floor
10. Bowel leakage: number of episodes:  
 no leakage  
 \_\_\_\_\_ times per day  
 \_\_\_\_\_ times per week  
 \_\_\_\_\_ times per month  
 only with physical exertion or cough  
On average, how much feces do you leak?  
 no leakage  
 stool staining  
 small amount in underwear  
 complete emptying
11. What form of protection do you wear? (choose only one)  
 none  
 minimal protection (tissue paper/paper towel/pantishield)  
 moderate protection (absorbent product/maxipad)  
 maximum protection (specialty product/diaper)  
 other \_\_\_\_\_
12. On the average, how many pad changes are required in 24 hours? \_\_\_\_\_ (# of pads)
13. Please check all activities or events that cause your symptoms?  
 strong urge to go  
 walking to the toilet  
 light activity (walking/light housework)  
 sexual activity  
 other (please specify) \_\_\_\_\_  
 coughing/sneezing/laughing/yelling  
 a change in position (i.e.- going from sit to stand)  
 vigorous activities (running/weight lifting/jumping)  
 **symptoms are not activity related**
14. How has your lifestyle/quality of life been changed or altered due to this problem?(check all that apply)  
 social activities (please specify) \_\_\_\_\_  
 diet or fluid intake (please specify) \_\_\_\_\_  
 physical activity (please specify) \_\_\_\_\_  
 work (please specify) \_\_\_\_\_
15. Please rate your feeling as to the severity of this problem from 0 – 10 with 0 = to no problem and 10 = the worst problem:  
0    1    2    3    4    5    6    7    8    9    10
16. Do you have any other complaints or concerns related to this problem? \_\_\_\_\_

# HEALTH SCREENING QUESTIONNAIRE

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

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 problem began.

## Medical History

- |                                   |                                   |
|-----------------------------------|-----------------------------------|
| Y/N High blood pressure           | Y/N Cancer (type) _____           |
| Y/N Diabetes                      | Y/N Asthma/Emphysema/COPD         |
| Y/N Neurologic/Multiple Sclerosis | Y/N Heart disease                 |
| Y/N Stroke/Head injury            | Y/N Broken bones/Joint problems   |
| Y/N Allergies                     | Y/N Low back pain/Sciatica        |
| Y/N Latex sensitivity or allergy  | Y/N Sexually transmitted diseases |
| Y/N Smoking habit                 | Y/N HIV/AIDS                      |
| Y/N Other please describe _____   |                                   |

Date of last pelvic/prostate exam \_\_\_\_\_ Date of urinalysis \_\_\_\_\_

Other tests \_\_\_\_\_

## 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 prostate         |
| Y/N Surgery for your female organs | Y/N Surgery for your abdominal organs |

Other/describe \_\_\_\_\_

## Ob/Gyn History (females only)

- |   |                                 |
|---|---------------------------------|
| Y/N Childbirth vaginal deliveries # _____ | Y/N Vaginal dryness             |
| Y/N Episiotomy # _____                    | Y/N Painful periods             |
| Y/N C-Section # _____                     | Y/N Menopause - when? _____     |
| Y/N Difficult childbirth # _____          | Y/N Painful vaginal penetration |
| Y/N Prolapse or organ falling out         | Y/N Pelvic pain                 |

Other /describe \_\_\_\_\_

## 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/describe \_\_\_\_\_

Explain all yes responses: \_\_\_\_\_

\_\_\_\_\_

## Medication

## Start date

## Reason for taking

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

# KEEPING A RECORD OF BLADDER FUNCTION

The main purpose of a bladder log is to document how your bladder functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns. At first, the log is used as an evaluation tool. Later, it will be used to measure your progress on bladder retraining or leakage episodes. **Please complete a bladder log every day for \_\_\_\_\_ days and bring it with you to your appointment.**

Your log will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of the day exactly what happened in the morning.

## INSTRUCTIONS

### Column 1 - Time of Day

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold. Select the hour block that corresponds with the time of day you are recording information.

### Column 2 - Type & Amount of Fluid & Food Intake

- Record the type and amount of **fluid** you drank
- Record the type and amount of **food** you ate
- Record when you woke up for the day and the hour you went to sleep

### Column 3 - Amount Voided (Urinated): Three methods

**Record the time of day and amount voided. Use the first method unless directed by your health care provider to directly measure or count urine amounts. Record a bowel movement with a BM at the appropriate time.**

1. Place an S, M, L, in the box at the corresponding time interval each time you urinate.  
S- SMALL= seemed like a small amount, or urinated “just in case”.  
M- MEDIUM= seemed like an 8 ounce measuring cup would run over.  
L- LARGE= seemed like the amount you urinate when you first wake up in the morning.
2. If you have difficulty gauging the amount of urine, you may record seconds by counting “one - one thousand” (this equals one second) while emptying your bladder. Record the total number of seconds it took you to void.
3. Measure urine amounts with a collection device. The best method is a collection “hat” that can be placed directly over the toilet. Ask your provider where to get one. Some people use 2-4 cup measuring containers, but it is sometimes difficult to catch the urine with these. Record the measured ounces of urine in the box at the corresponding time interval each time you urinate.

### Column 4 - Amount of Leakage

**Record the amount of urine loss at the time it occurred. Count seconds as one one thousand, two one thousand, etc.**

### Column 5 - Was Urge Present

**DESCRIBE THE URGE SENSATION YOU HAD AS:**

- 1- MILD= first sensation of need to go
- 2- MODERATE= stronger sensation or need
- 3- STRONG= need to get to toilet, move aside!

**COLUMN 6 - ACTIVITY WITH LEAKAGE**

**DESCRIBE THE ACTIVITY ASSOCIATED WITH THE LEAKAGE, I.E. COUGHED, HEARD RUNNING WATER, SNEEZED, BENT OVER, LIFTED SOMETHING OR HAD A STRONG URGE.**

**Comments** – (at the bottom of the log table) Special problems and new or changes in medication are recorded here. If a pad change was needed, record the number used during the day at the bottom of the page.

**Daily Voiding Log Sample**

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided in Ounces or S /M /L or seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am	Woke up at 6:45 am	L		3	
7:00 am	Coffee, bagel				
8:00 am			M		Fast walking
9:00 am	Apple	M		2	
10:00 am					
11:00 am		S		1	Key in the door
<b>NOON</b>	Tuna sandwich, milk, pear				
<b>1:00 pm</b>					
<b>2:00 pm</b>		M		2	
<b>3:00 pm</b>	Tea, cookies		S		Running water
<b>4:00 pm</b>					
<b>5:00 pm</b>					
<b>6:00 pm</b>	Chicken, corn pudding, salad, apple juice	M		3	
<b>7:00 pm</b>					
<b>8:00 pm</b>			S	3	
<b>9:00 pm</b>					
<b>10:00 pm</b>	To bed at 10:30	M		3	
<b>11:00 pm</b>					

Comments: week before period

Number of pads: \_\_\_\_\_

# DAILY VOIDING LOG

Name \_\_\_\_\_

Date \_\_\_\_\_

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided # Seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
<b>Midnight</b>					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
<b>Noon</b>					
<b>1:00 pm</b>					
<b>2:00 pm</b>					
<b>3:00 pm</b>					
<b>4:00 pm</b>					
<b>5:00 pm</b>					
<b>6:00 pm</b>					
<b>7:00 pm</b>					
<b>8:00 pm</b>					
<b>9:00 pm</b>					
<b>10:00 pm</b>					
<b>11:00 pm</b>					

Comments \_\_\_\_\_

**Number of pads used today** \_\_\_\_\_

# DAILY VOIDING LOG

Name \_\_\_\_\_

Date \_\_\_\_\_

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided # Seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
<b>Midnight</b>					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
<b>Noon</b>					
<b>1:00 pm</b>					
<b>2:00 pm</b>					
<b>3:00 pm</b>					
<b>4:00 pm</b>					
<b>5:00 pm</b>					
<b>6:00 pm</b>					
<b>7:00 pm</b>					
<b>8:00 pm</b>					
<b>9:00 pm</b>					
<b>10:00 pm</b>					
<b>11:00 pm</b>					

Comments \_\_\_\_\_

**Number of pads used today** \_\_\_\_\_

# DAILY VOIDING LOG

Name \_\_\_\_\_

Date \_\_\_\_\_

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided # Seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
<b>Midnight</b>					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
<b>Noon</b>					
<b>1:00 pm</b>					
<b>2:00 pm</b>					
<b>3:00 pm</b>					
<b>4:00 pm</b>					
<b>5:00 pm</b>					
<b>6:00 pm</b>					
<b>7:00 pm</b>					
<b>8:00 pm</b>					
<b>9:00 pm</b>					
<b>10:00 pm</b>					
<b>11:00 pm</b>					

Comments \_\_\_\_\_

**Number of pads used today** \_\_\_\_\_