PELVIC SYMPTOM QUESTIONNAIRE

Date:_____ Name: _____ DOB: _____

1. Describe the current problem that brought you here: _____

2. When did your problem first begin? _____

3. Was your first episode of the problem related to a specific incident? Yes/No

4. Since that time is it: staying the same_____ getting worse_____ getting better _____
Why or how? _____

5. If pain is present, rate pain on a 0-10 scale. 10 being the worst: _____

6. Describe the nature of the pain (i.e. constant burning, intermittent ache, etc) _____

7. Describe previous treatment/exercises: _____

8. Activities/events that cause or aggravate your symptoms. Check/Circle all that apply.

_ Sitting greater than __ minutes
_ Walking greater than __ minutes
_ Standing greater than __ minutes
_ Changing positions (i.e. sit to stand)
_ Light activity (light housework)
_ Sexual activity
_ With cough/sneeze/straining
_ With laughing/yelling
_ With lifting/bending
_ With cold weather
_ With nervousness/anxiety
_ No activity affects the problem
_ Other, please list: _____

9. What relieves your symptoms? _____

10. How has your lifestyle/quality of life been altered/changed because of this problem:
Social activities (exclude physical activities)_____
Diet/Fluid Intake_____
Physical activity_____
Work_____
Other_____

11. Rate the severity of this problem from 0-10 with 0 being no problem and 10 being worst:_____

12. What are your treatment goals/concerns?_____

Since the onset of your current symptoms, have you had:

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder function
Y/N Malaise (unexpected tiredness)
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness/tingling
Y/N Other_____
Date of last physical exam_____ Tests performed_____

PELVIC SYMPTOM QUESTIONNAIRE

General Health: Excellent Good Average Fair Poor Occupation_____
Hours per week worked__ On disability or leave Y/N Activity Restrictions? Y/N _____
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe_____
Mental Health: Current level of stress High__ Med__ Low__ Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply:

Cancer	Stroke	Emphysema/Chronic Bronchitis
Heart Problems	Epilepsy	Asthma
High Blood Pressure	M.S.	Allergies_____
Ankle Swelling	Head Injury	Latex Sensitivity
Anemia	Osteoporosis	Hypothyroid/Hyperthyroid
Low Back Pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone Pain	Fibromyalgia	Diabetes
Alcohol/Drug Problems	Arthritis	Kidney Disease
Childhood Bladder Problems	Stress Fracture	Irritable Bowel Syndrome
Depression	Acid Reflux	Hepatitis
Anorexia/Bulimia	Joint Replacement	Sexually Transmitted Diseases
Smoking History	Bone Fracture	Physical or Sexual Abuse
Vision/Eye Problems	Sports Injuries	Raynaud's (cold hands or feet)
Hearing Loss/Problems	TMJ/Neck Pain	Pelvic Pain

Other_____

Surgical/Procedure History

Y/N Surgery for your back/spine	Y/N Vaginal Dryness
Y/N Surgery for your brain	Y/N Surgery for your bones or joints
Y/N Surgery for your female organs	Y/N Surgery for your abdominal organs

Other_____

Ob/Gyn (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/genital pain

Y/N Other_____

Males Only

Y/N Prostate disorders	Y/N Erectile dysfunction
Y/N Shy bladder	Y/N Painful ejaculation

Y/N Pelvic/genital pain location _____

PELVIC SYMPTOM QUESTIONNAIRE

Medications

Name *Start Date* *Reason*

Bladder/Bowel Habits/Symptoms

Y/N Trouble initiating urine stream
Y/N Urinary intermittent/slow stream
Y/N Strain or push to empty bladder
Y/N Difficulty stopping urine stream
Y/N Trouble emptying bladder completely
Y/N Blood in urine
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Trouble feeling bladder urge/fullness
Y/N Recurrent bladder infections
Y/N Painful urination
Y/N Other_____

Y/N Blood in stool/feces
Y/N Painful bowel movements
Y/N Trouble feeling bowel urge/fullness
Y/N Seepage/loss of BM without awareness
Y/N Trouble controlling bowel urge
Y/N Trouble holding back gas/feces
Y/N Need to support/touch to complete BM
Y/N Trouble emptying bowel completely
Y/N Staining of underwear after BM
Y/N Constipation/straining ____% of the time
Y/N Current laxative use? Type_____

Describe typical position for emptying:_____

1. Frequency of urination: Awake hours_____ times per day. Sleep hours_____ times per night
2. 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
3. The usual amount of urine passed is ___ small ___ medium ___ large
4. Frequency of bowel movements: _____ times per day. _____ times per week. Or _____
5. The bowel movements are typically: watery___ loose___ formed___ pellets___ other_____
6. 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_____
7. If constipation is present, describe management techniques_____

8. Average fluid intake (one glass is 8 oz or one cup)_____ glasses per day
of this, how many glasses are caffeinated?_____

9. Rate a feeling of organ “falling out”/prolapse or pelvic heaviness/pressure:
None present
_Times per month (specify if related to menstrual period)
_ With standing for ___ minutes or ___ hours
_ With exertion or straining
Other_____

PELVIC SYMPTOM QUESTIONNAIRE

10 a. Bladder leakage – number of episodes
_ No leakage
_ Times per day
_ Times per day
_ Times per month
_ Only with physical exertion/cough

10 b. Bowel leakage – number of episodes
_ No leakage
_ Times per day
_ Times per day
_ Times per month
_ Only with exertion/strong urge

11 a. On average, how much urine do you leak?
_ No leakage
_ Just a few drops
_ Wets underwear
_ Wets the floor
_ Just a few drops

11 b. How much stool do you lose?
_ No leakage
_ Stool staining
_ Small amount in underwear
_ Complete emptying
_ Other_____

12. What form of protection do you wear?
_ None
_ Minimal protection (tissue paper/paper towel/pantishields)
_ Moderate protection (absorbent product, maxi pad)
_ Maximum protection (specialty product/diaper) _ Other_____

CONDITIONS & CONSENT FOR PELVIC FLOOR PHYSICAL THERAPY

COOPERATION WITH TREATMENT: ***(Please read and initial)***

___ I understand that in order for physical therapy to be effective, I must come as schedule unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist

___ I may be discharged from physical therapy if I fail to keep three (3) appointments without calling to cancel.

___ I understand that my therapist will offer me options to help me make decisions regarding my Plan of Care.

___ I agree to provide accurate and complete medical information.

NO WARRANTY: ***(Please read and initial)***

___ I understand that PRO Therapy, Inc. cannot make any promises or guarantees regarding a cure for or improvement of 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 treatment options with me before I consent to treatment.

TREATMENT CHOICES:

- Physical therapy does not promise a cure for your condition. The therapist will provide a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

- Treatment procedures for pelvic floor dysfunctions' include, without limitation, education, exercise, stimulation, ultrasound, use of vaginal weights, and several manual techniques including massage, joint and soft tissue mobilization. The therapist will explain all these treatment procedures to me and I may choose to not participate with all or part of the treatment plan. I understand that no guarantees have been or can be provided to me regarding the success of therapy.

(Please read and initial)

___ **Potential risks:** I understand 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 24 hours, I agree to contact my physical 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.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits, and alternatives of the treatment. I understand that I may withdraw at any time.

Based on the information I have received from the therapist, I understand my treatment options. I have been given the opportunity to participate in my Plan of Care and voluntarily agree to the treatment procedures discussed.

_____ patient signature and date

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 compete a bladder log every day for 2-3 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 woek 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 a 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.
   (this equals one second) while emptying your bladder. Record the total number of seconds it took you to void.
2. If you have difficulty gauging the amount of urine, you may recored 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.

S- SMALL=drop or two of urine
M- MEDIUM=wet underwear
L- LARGE= wet outerwear or floor

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!

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 a.m.					
2:00 a.m.					
3:00 a.m.					
4:00 a.m.					
5:00 a.m.					
6:00 a.m.	Woke up at 6:45 a.m.	L		3	
7:00 a.m.	Coffee, Bagel				
8:00 a.m.			M		Fast Walking
9:00 a.m.	Apple	M		2	
10:00 a.m.					
11:00 a.m.		S		1	Key in the door
NOON	Tuna sandwich, milk, pear				
1:00 p.m.					
2:00 p.m.		M		2	
3:00 p.m.	Tea, cookies		S		Running water
4:00 p.m.					
5:00 p.m.					
6:00 p.m.	Chicken, corn pudding, salad, apple juice	M		3	
7:00 p.m.					
8:00 p.m.			S	3	
9:00 p.m.					
10:00 p.m.	To bed at 10:30	M		3	
11:00 p.m.					

Comments: week before period

Number of pads: 2

PELVIC SYMPTOM QUESTIONNAIRE

Daily Bladder Voiding Log

Name: _____ Date: _____

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 a.m.					
2:00 a.m.					
3:00 a.m.					
4:00 a.m.					
5:00 a.m.					
6:00 a.m.					
7:00 a.m.					
8:00 a.m.					
9:00 a.m.					
10:00 a.m.					
11:00 a.m.					
NOON					
1:00 p.m.					
2:00 p.m.					
3:00 p.m.					
4:00 p.m.					
5:00 p.m.					
6:00 p.m.					
7:00 p.m.					
8:00 p.m.					
9:00 p.m.					
10:00 p.m.					
11:00 p.m.					

Comments: _____ Number of pads: ____

PELVIC SYMPTOM QUESTIONNAIRE

Daily Bladder Voiding Log

Name: _____ Date: _____

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 a.m.					
2:00 a.m.					
3:00 a.m.					
4:00 a.m.					
5:00 a.m.					
6:00 a.m.					
7:00 a.m.					
8:00 a.m.					
9:00 a.m.					
10:00 a.m.					
11:00 a.m.					
NOON					
1:00 p.m.					
2:00 p.m.					
3:00 p.m.					
4:00 p.m.					
5:00 p.m.					
6:00 p.m.					
7:00 p.m.					
8:00 p.m.					
9:00 p.m.					
10:00 p.m.					
11:00 p.m.					

Comments: _____ Number of pads: ____

PELVIC SYMPTOM QUESTIONNAIRE

Daily Bladder Voiding Log

Name: _____ Date: _____

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 a.m.					
2:00 a.m.					
3:00 a.m.					
4:00 a.m.					
5:00 a.m.					
6:00 a.m.					
7:00 a.m.					
8:00 a.m.					
9:00 a.m.					
10:00 a.m.					
11:00 a.m.					
NOON					
1:00 p.m.					
2:00 p.m.					
3:00 p.m.					
4:00 p.m.					
5:00 p.m.					
6:00 p.m.					
7:00 p.m.					
8:00 p.m.					
9:00 p.m.					
10:00 p.m.					
11:00 p.m.					

Comments: _____ Number of pads: ____