LAKE CENTRE for REHAB

Dear New Patient:

To help treat your condition, your doctor has recommended a type of physical therapy called ***Pelvic Floor Physical Therapy***. If you are unfamiliar with this type of therapy, you are not alone. However, research points to its high success rate, all without drugs or surgery. In fact, over 90% of our patients report an 80-100% improvement in their symptoms by the end of therapy, and only 1-2% report no change at all. So, the odds are very good that we will be able to help you.

Many bowel, bladder, and pain conditions in the pelvis are due to poorly functioning muscles. Your "pelvic floor" is a muscle group at the bottom of your pelvis that has two main functions: 1) postural support to the pelvic organs (bladder, bowel, uterus, and prostate) and 2) voluntary control over bowel and bladder function.

Pelvic Floor Muscle Dysfunction Categories

1. **Weak and sagging**
   - Loss of control over your bladder or bowels (incontinence)
   - Pelvic organ prolapse (fallen bladder, bowels, and/or uterus)

2. **Tight and spasming**
   - Trouble with elimination (urinary retention, constipation)
   - Pelvic pain (with sitting, during intercourse)

Pelvic Floor Rehab is ***not*** the same as Kegel exercises. Like traditional physical therapy, we will use techniques that will strengthen weak muscles and stretch and massage tight muscles. Our team has expert training in how to modify traditional therapy techniques in order to treat the pelvic floor area in ways that will make you feel comfortable.

Please take the time to fill out the enclosed questionnaire. It will help us better plan your treatment. There may be questions that at first, you wouldn't think would apply to you, but since pelvic floor problems can affect bowel, bladder and sexual function, it is not uncommon to have symptoms in more than one category.

Your evaluation and first treatment with your therapist will take about an hour, will be one-on one, and in a private, quiet area. Please dress in comfortable, loose-fitting clothing. You are welcome to bring a friend or family member with you. Most patients will require 12-16 treatment sessions that will last about 45-60 minutes each. Please call with any questions or concerns you might have. We look forward to meeting you.

Sincerely,

Your Pelvic Floor Rehab Team

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Male Pelvic Floor Questionnaire

Patient Name: _____ **DOB:** _____

Conditions related to the pelvic floor muscles can affect bladder, bowel, sexual, and physical function. Please answer the questions below so that we can better understand your problem. Please check all that apply.

History of Current Condition

Reason for today's visit_____

How long have you had this problem?_____

Since the problem began, has the problem become: ❑Worse ❑ Better ❑ Unchanged

Is it related to an injury or accident? ❑ No ❑ Yes Explain how and when_____

What are your goals for treatment?_____

Previous Treatments for your condition

❑ Prostatectomy	❑ Kegel exercises	❑ Hemorrhoid repair	❑ Massage therapy
❑ Radiation	❑ Biofeedback	❑ Ostomy pouch	❑ Chiropractor
❑ Seed implantation	❑ Pelvic floor rehab	❑ Hemorrhoid cream	❑ Acupuncture
❑ Cyrotherapy	❑ Diet/fluid changes	❑ High fiber diet	❑ Over the counter pain meds
❑ Proton therapy	❑ Bladder control meds	❑ Probiotics	❑ Prescription pain meds
❑ Lupron/hormones	❑ Collagen injections	❑ Stool softeners	❑ Bladder instillations
❑ Greenlight ablation	❑ Self-catheterization	❑ Constipation meds	❑ Urethral/bladder dilation
❑ TURP	❑ InterStim	❑ Anti-diarrheal meds	❑ Bladder instillations
❑ BCG treatments	❑ Artificial sphincter	❑ Herbal supplements	❑ Nerve injections/blocks
❑ Condom catheter	❑ Penile clamp	❑ Enemas	❑ Other:_____

Have you received therapy for the current or other problem in the past year? ❑ Yes ❑ No If yes, indicate type (physical therapy, speech therapy, etc.) and date. _____

Previous Tests for you condition:

❑ Urodynamics study	❑ Video defacography	❑ X-ray	❑ Digital rectal exam
❑ Bladder scan (PVR)	❑ Colonoscopy	❑ CT scan	❑ Prostate biopsy
❑ Cystoscopy	❑ Anal manometry	❑ MRI	❑ Exploratory surgery

Medical Conditions and Health Status

Please rate your overall health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

With whom do you live? ❑ Alone ❑ Spouse/significant other ❑ Other relative(s) ❑ Roommate(s)

Where do you live? ❑Private home or apartment ❑ Independent living ❑ Assisted living

❑ Other_____

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Patient Name: _____ **DOB:** _____

Prostate	❑ Enlarged prostate (BPH) ❑ Prostate infections ❑ Chronic prostatitis ❑ Prostate pain ❑ Erectile dysfunction ❑ Erectile/ejaculation pain ❑ Prostate cancer: If so, when were you diagnosed? _____ What was your Gleason score? _____ ❑ Last PSA reading: _____		
	Sexual Function: ❑ I'm sexually active ❑ I'm not sexually active due to: ❑ My pelvic pain symptoms ❑ *My other* medical problems ❑ For non-health related reasons ❑ *My partner's* medical problems		
Bladder	❑ Urinary incontinence ❑ Small bladder capacity ❑ Bladder cancer ❑ Bladder infections (UTI's) ❑ Large bladder	❑ Overactive bladder ❑ Kidney stones ❑ Urinary retention ❑ Painful bladder Syndrome ❑ Interstitial cystitis ❑ Other _____	
Bowels	❑ Fecal incontinence ❑ Constipation ❑ Diarrhea ❑ Irritable bowel syndrome ❑ Ulcerative colitis ❑ Spastic colon ❑ Diverticulitis ❑ Diverticulosis	❑ Hemorrhoids ❑ Lactose intolerance ❑ Gluten intolerance ❑ Other _____ ❑ Colon cancer ❑ Anal cancer ❑ Colostomy/ileostomy	
Other Medical	❑ High blood pressure ❑ Low blood pressure ❑ High cholesterol ❑ Heart disease ❑ Heart attack ❑ Angina ❑ Congestive heart failure ❑ Cardiac arrhythmia ❑ Pacemaker/defibrillator ❑ Vascular disease ❑ Swollen legs/edema ❑ Emphysema ❑ Bronchitis ❑ Asthma ❑ Cigarette smoker ❑ Former smoker ❑ Migraine headaches ❑ Stroke	❑ TIA (mini strokes) ❑ Parkinson's Disease ❑ Multiple Sclerosis ❑ Seizures ❑ Hypothyroidism ❑ Kidney disease ❑ Kidney stones ❑ Sleep apnea ❑ Diabetes ❑ Acid reflux ❑ Depression ❑ Anxiety disorder ❑ Glaucoma ❑ Cataracts ❑ Glasses ❑ Hearing loss ❑ Fibromyalgia	❑ Osteoporosis ❑ Osteopenia ❑ Low back pain ❑ Tailbone trauma ❑ Sciatica ❑ Stenosis ❑ Arthritis Area_____ ❑ Herniated disc Level_____ ❑ Degenerative disc Area_____ ❑ Bone fracture Area_____ ❑ Cancer Area_____ ❑ Other_____

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Patient Name: _____ **DOB:** _____

Surgeries	Age or Year	Medications	For what condition?

Allergies

❑ None ❑ Latex sensitivity ❑ Seasonal (pollen/hay fever) ❑ Bees ❑ Other_____

❑ Medications: _____

Review of Systems – Please check if you have recently had any of these symptoms.			
❑ Fever/chills	❑ Eye pain/redness	❑ Stomach pain	❑ Tremors
❑ Weight change	❑ Chest pain	❑ Bloody stools	❑ Speech changes
❑ Fatigue/night sweats	❑ Pounding heart	❑ Tarry stools	❑ Seizures
❑ Skin rash/itch	❑ Shortness of breath	❑ Blood in urine	❑ Loss of consciousness
❑ Headaches	❑ Calf pain	❑ Muscle pain	❑ Vertigo/spinning
❑ Hearing loss	❑ Leg swelling	❑ Neck/back pain	❑ Unsteadiness
❑ Ringing in ears	❑ Cough	❑ Joint pain	❑ Lightheaded
❑ Ear pain/discharge	❑ Coughing up blood	❑ Falls	❑ Depression
❑ Nose bleeds	❑ Phlegm production	❑ Arm/leg weakness	❑ Nervous/anxious
❑ Sore throat	❑ Congestion	❑ Lack of coordination	❑ Suicidal thoughts
❑ Blurred vision	❑ Wheezing	❑ Difficulty walking	❑ Hallucinations
❑ Double vision	❑ Heartburn	❑ Difficulty standing up	❑ Substance abuse
❑ Light sensitive	❑ Nausea/vomiting	❑ Tingling/numbness	❑ Memory loss
Is your doctor aware of these recent symptoms? ❑ Yes ❑ No			

Please answer the questions below. If your symptoms fluctuate in severity, characterize your symptoms at their worst.

Bladder Health

Do you have a urologist? ❑ Yes ❑ No If yes, who?_____

1. During the **daytime**, how often do you urinate? ❑ Every 30-60 minutes ❑ 1-2 hours ❑ 2-3 hours ❑ 3-4 hours ❑ More than 4 hours
2. During the **nighttime** (after you've fallen asleep), how often do you get up to urinate?
   ❑ 0-1 times per night ❑ 2-3 times ❑ 3-4 times ❑ More than 4 times

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Patient Name: _____ **DOB:** _____

3. How many **8**-ounce **servings** (cups) do you drink of the following?

Liquid	Per Day	Per Week	On Occasion	Never
Coffee (❑ Reg. ❑ Decaf)				
Tea (❑ Reg. ❑ Decaf)				
Soda (❑ Reg. ❑ Decaf)				
Beer/Wine/Liquor				
Water				
Milk				
Juice				
Other:_____				

4. Do you **ever lose urine (even a few drops)** with any of the situations below?

	Never	On Occasion	Sometimes	Usually	Always
Cough					
Sneeze					
Laugh					
Getting out of a chair					
Getting out of a car					
Getting out of bed at night					
Getting out of bed in the morning					
Picking objects off the floor					
Putting on shoes or clothes					
Lifting light items					
Lifting heavy items					
Cooking or doing dishes					
Doing housework/chores					
Doing yard work					
During sexual activity					
Walking to the toilet at home					
Shopping or running errands					
Standing or walking for a long time					
Recreational activities					
Exercise activities					
Other _____					

5. Do you ever have **strong or difficult-to-control urges** to urinate with the situations listed below?

	Never	On occasion	Sometimes	Usually	Always
Around running water					
Feeling cold					
Feeling anxious or nervous					
Unlocking the door					
If I've waited too long					
Rushing off to the toilet					

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6. How long can you **usually delay an urge** to urinate? ❑ I rarely feel urges to void ❑ I go as soon as I feel an urge ❑ 1-2 minutes ❑ Several minutes ❑ 10-15 minutes ❑ 15 minutes or more
7. What **type of protective padding** do you use for bladder control? ❑ None needed ❑ Change underwear ❑ Folded tissue paper ❑ Liners ❑ Thin pads ❑ Thick pads ❑ Diapers ❑ Other_____
8. How often do you **change your bladder protection**? ❑ None ❑ Only when I leave the house ❑ Only at night ❑ Only during a cold ❑ Only during exercise ❑ 1-2 per day ❑ 3-4 per day ❑ 4+ per day
9. How **saturated** does your protection get? ❑ No leakage ❑ "Near misses" ❑ A few drops ❑ Damp ❑ Wet ❑ Soaked ❑ Overflows onto clothes
10. How often do you go to the bathroom **before you feel urges** to void, "just in case?" ❑ Never ❑ On occasion ❑ Sometimes ❑ Usually ❑ Always
11. How often do you **avoid drinking** fluid in order to help with bladder control? ❑ Never ❑ On occasion ❑ Sometimes ❑ Usually ❑ Always
12. Do you ever notice any of the following **bladder symptoms**? Please check how often.

	Never	On occasion	Sometimes	Usually	Always
Weak stream					
Incomplete bladder emptying					
Trouble starting urine stream					
Strain to urinate					
Dribble after urinating					
Have to rock pelvis to empty bladder					
Have to push over the bladder to empty					
Splint or support bladder to urinate					
Pain as my bladder *fills*					
Location:	❑ Bladder ❑ Urethra ❑ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bladder *empties*					
Location:	❑ Bladder ❑ Urethra ❑ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

Bowel Health

Do you have a gastroenterologist? ❑ Yes ❑ No If yes, who?_____

1. **How often** do you have a bowel movement? ❑ Less than 3 times a week ❑ Every 2-3 days ❑ Every 1-2 days ❑ Daily ❑2-3 times per day ❑ More than 3 times per day ❑ I won't go for several days, and then go multiple times in one day
2. What is the **consistency** of your bowel movements? ❑ Watery/formless ❑ Loose and thin ❑ Soft and formed ❑ Hard and rocky ❑ Small and pellet-like ❑ It varies_____

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Patient Name: _____ **DOB:** _____

3. Do you ever **lose feces** with any of the situations below? Please check how often.

	Never	On Occasion	Sometimes	Usually	Always
On the way to the toilet					
If I exert myself					
When I pass gas					
I have fecal soiling without an urge to have a BM					

4. What **type of protective padding** do you use for bowel control? ❑ None needed ❑ Change underwear ❑Folded tissue paper ❑ Liners ❑ Thin pads ❑ Thick pads ❑ Diapers ❑ Other_____

5. How often do you **change your bowel protection**? ❑ None ❑ Only when I leave the house ❑ Only when I have diarrhea/ loose stools ❑ 1-2 per day ❑ 3-4 per day ❑ 4+ per day

6. Do you ever notice any of the following **bowel symptoms**? Please check how often.

	Never	On occasion	Sometimes	Usually	Always
Excessive straining during a BM					
Support/splint rectum during BM					
Incomplete BM's					
Rush to the toilet with BM urge					
Trouble controlling gas in public					
Excessive wiping needed after BM					
Fecal soiling in underwear after BM					
Pain as my bowels *fill*					
Location:	❑ Rectum ❑ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				
Pain as my bowels *empty*					
Location:	❑Rectum ❑ Abdomen				
Circle severity:	No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain				

Pelvic Pain Symptoms:

❑ None

❑ My pelvic symptoms **affect my ability** to, OR **I feel worse when I try** to: Check all that apply.

❑ Sleep	❑ Bend forward	❑ Perform work duties
❑ Bathe	❑ Squat down	❑ Recreational activities
❑ Get dressed	❑ Lift items	❑ Social events
❑ Wear tight clothing	❑ Reach overhead	❑ Travel
❑ Cook meals	❑ Get out of bed	❑ Exercise for health
❑ Do housework	❑ Stand up from a chair	❑ Do Kegel exercises
❑ Do yard work	❑ Get out of a car	

Patient Name: _____ **DOB:** _____

Pain location:

Circle pain severity: No Pain 0__1__2__3__4__5__6__7__8__9__10 Worst Pain

Check all that apply.

❑ Abdomen	❑ Front of hips
❑ Scrotum	❑ Rectum
❑ Buttocks	❑ Sides of Hips
❑ Groin	❑ Bladder
❑ Over tight surgical scars	❑ Tailbone
❑ Penis	❑ Side/waist
❑ Low back	❑ Urethra
❑ Inner thighs	❑ Back of hips

Pain with sexual activity:

Circle pain severity: No Pain 0__1__2__3__4__5__6__7__8__9__10 Worst Pain

Check all that apply.

❑ None
❑ I have to *interrupt* intercourse due to pain.
❑ I limit the *frequency* of sexual activity because of my pain.
❑ I *avoid it* altogether due to my pain. Last intercourse attempt: _____

The pain occurs during: ❑ During erection ❑ During ejaculation

For how long? ❑ Only during sexual activity ❑ For a few hours afterwards ❑ For a day or more afterwards

Location: ❑ Penis/scrotum ❑ Deep in my pelvis ❑ In my back

_____ _____
Patient/Guardian Signature Date

_____
Printed name and relationship to patient

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PELVIC FLOOR INFORMED CONSENT FOR EVALUATION AND TREATMENT OF PELVIC FLOOR DYSFUNCTIONS

Patient Name: _____ DOB: _____

The term, "informed consent," means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to me. 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 understand I have been referred to therapy for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include 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.

As part of your evaluation and treatment for pelvic floor dysfunction, your therapist may initially and periodically perform an internal assessment of the pelvic floor muscles, assessing muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. This examination is performed by observing and/or palpating the perineal region including the rectum. The findings will be discussed with you, and you will collaborate with your therapist to develop a treatment plan that is appropriate for YOU. Please discuss any concerns or hesitations that you may have with your therapist.

Treatment procedures for pelvic floor dysfunctions may include, without limitation, education, exercise, stimulation, ultrasound, and manual therapy techniques including massage, joint and soft tissue mobilization. The therapist will explain all the treatment procedures prior to performing, and you may choose to not participate in all or part of the treatment.

I understand that the benefits of the rectal assessment have been explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist, and the procedure will be discontinued, and an alternative discussed with me.

I understand that no guarantees have been or can be provided to me regarding the success of therapy.

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

You have the option of having a second person in the room for the pelvic floor muscle evaluation and treatment. The second person could be a friend, family member, or clinic staff member. Please indicate your preference with your initials:

_____ **YES,** I want a second person present during the pelvic floor muscle evaluation and treatment.
_____ **NO,** I do not want a second person during the pelvic floor muscle evaluation and treatment.
_____ I would like to discuss my options with my physical therapist prior to consenting.

By signing this form, I understand that treatment as indicated above may be necessary for effective treatment of my problem and any questions I may have had have been answered to my satisfaction. I understand the risk, benefits, and alternative treatments.

I have read and understand the Informed Consent for Pelvic Floor Muscle Evaluation and Treatment, and I consent to the evaluation and treatment.

_____ _____
Patient/Guardian Signature Date

_____
Printed name and relationship to patient