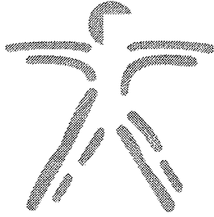

FYZICAL THERAPY AND BALANCE CENTERS OF PORT TOWNSEND

Ph: (360) 385-1035 Fax: (360) 385-4395
1215 Lawrence Street Suite 101 Port Townsend, WA 98368

INFORMATION ON TREATMENT FOR PELVIC FLOOR DYSFUNCTION RELATED TO BOWEL AND BLADDER PROBLEMS

Thank you for choosing FYZICAL THERAPY AND BALANCE CENTERS.

To prepare you for your first visit and to make this visit as productive as possible, please **complete** the handouts we are sending you:

i. History Questionnaire.
ii. Daily Voiding Log with explanation.

All of the attached forms MUST be completed PRIOR to your first appointment.

{If this is too overwhelming, please call us and we will make other arrangements.}

Begin the Voiding Log now (if incontinence is your diagnosis).

- Read the directions "Keeping a record of your bladder function" carefully.
- Then keep track of your food and water intake and urination/bowel movements for 2 full days and nights. There are two identical forms provided for this purpose.

Complete the Patient History form next.

When you come in for your visit on ________________ at ____________,
please arrive 15 minutes early to complete the regular office paperwork.
Plan on 60 minutes for the first evaluation visit and 45-60 minute visits thereafter.

The Physical Therapy evaluation and first treatment may include:

- Review of your history
- Musculoskeletal and pelvic floor muscle exam
- Biofeedback measurements to assess baseline strength of your pelvic floor. This machine records your muscle activity to help to treat your pelvic floor muscles.
- Exercise instruction for pelvic floor muscles.
- The plan for further visits.

Return visits will be scheduled at regular intervals to measure your progress and teach you all the components you need to overcome this challenge. These appointments are important to attend in order to progress your treatment program. Come even if you did not follow your home program perfectly. We understand it takes time to change habits.

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

If you have any questions, please telephone us at (360) 683-0632.

We look forward to meeting you.

FYZICAL THERAPY AND BALANCE CENTERS OF SEQUIM: PELVIC FLOOR HEALTH INTAKE FORM

Patient Name: ___________________________________ Evaluation Date: _________________________

Pelvic Health History: Check all that you are experiencing:

___ Urinary Incontinence
___ Anal Incontinence (unintentional loss of stool)
___ Pelvic Prolapse (organ falling out or pressure in perineum)
___ Urgency
___ Too Frequent of Voiding
___ Pelvic Pain

When did your problem first begin?
Was your first episode of the problem related to a specific incident? Yes/No _________________________
Since that time is it: ___ staying the same ___ getting worse ___ getting better.
What prior treatments have you tried for this condition? (circle)
None, Medical Doctor, Chiropractic, Naturopath, Acupuncture, Exercise, Medications, Surgery, Devices, Physical therapy, Biofeedback, Nutrition/change in diet, other _______________________________

Health History:

General Health: Excellent Good Average Fair Poor Occupation ___________________
Mental Health: Current level of stress __High__ Med__ Low Current counseling? Yes/No
Activity/Exercise: ___ None ___describe____

Social History: __ live alone ___live with spouse Do you feel safe in your current home situation?Yes/No

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

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Other:

Surgical /Procedure History (circle)
bladder/prostate, brain, reproductive organs, abdominal organs, bones/joints, back/spine
List:

Bladder and Bowel Habits(check all that apply)

___ Trouble initiating urine stream	___ Painful urination
___ Urinary stream is weak.	___ Trouble feeling bladder urge/fullness
___ Trouble emptying bladder completely	___ Pain when passing stool
___ Difficulty stopping the urine stream	___ Blood in Stool
___ Recurrent bladder infections	___ Trouble feeling bowel urge/fullness
___ Must strain or push to empty bladder.	___ Constipation or must strain to evacuate stool
___ Dribbling after urination	___ Trouble holding back gas/feces
___ Constant urine leakage	___ Strong sense of urgency for bowel movement (BM)
___ Blood in urine	___ Feel bowels are not completely empty after BM

Number of times urinate during day ___ during night ___ Number bowel movements per day ___ per week___

Sexuality: Are you currently sexually active? Yes/No. Hx of STD? Yes/No. History of abuse or rape? Yes/No

Ob/Gyn History (Females)

Number of Pregnancies; ___ Number of vaginal deliveries; ___ Number of Cesarean Section deliveries; ___
Complications: (circle). Severe tearing, Forceps, Episiotomy, Vacuum extraction, Baby over 8 lbs,
Menopause? Yes/No. Date ____ Pain with vaginal penetration? Yes/No Vaginal dryness? Yes/No

Urogenital History (Males) Circle

Prostate disorders, Erectile dysfunction, Shy bladder, Pelvic pain, Painful ejaculation
Able to achieve an erection? Yes/No Able to maintain an erection? Yes/No Pain with an erection? Yes/No
Other : describe____

FYZICAL THERAPY AND BALANCE CENTERS OF SEQUIM: PELVIC FLOOR HEALTH INTAKE FORM

Patient Name: ____________________________________Evaluation Date: _________________________

URINARY INCONTINENCE SECTION: _____ NOT APPLICABLE

Activities/events that **cause or aggravate** your symptoms. (Check all that apply)

___ Sitting greater than___ minutes
___ Walking greater than ___minutes
___ Standing greater than __ minutes
___ Changing positions (i.e. stand from sitting).
___ Light activity
___ With anxiety or stress
___ Sexual activity/ intercourse.
___ Other, please list ______________
___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers (i.e. running water or key in door)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sleeping

What **relieves** your symptoms?____

How has your **lifestyle or quality of life** been altered or changed because of this problem?

Household chores (cooking, cleaning, laundry)? __not at all __ slightly __ moderately__ greatly
Physical recreation (walking, swimming, etc.)? __not at all __ slightly __ moderately__ greatly
Entertainment activities (movies, concerts, etc.)? __not at all __ slightly __ moderately__ greatly
Traveling activities for more than 30 minutes (car, bus)? __not at all __ slightly __ moderately__ greatly
Social activities outside home (including work)? __not at all __ slightly __ moderately__ greatly
Emotional health (nervousness, depression, etc.? __not at all __ slightly __ moderately__ greatly
Other____

How much does leaking urine **interfere** with your everyday life? (0= not at all to 10=a great deal) Rated at ___

How **often** do you leak urine __ never, __ about once a week or less, __ 2-3 times a week __ about once per day __ several times per day __ all the time.

On average, how **much** urine do you USUALLY leak (whether you wear protection or not)?

__ No leakage
__ Just a few drops= small amount
__ Wets underwear= moderate amount
__ Wets outerwear= large amount
__ Wets the floor

What form of **protection** do you wear?

___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
___Other ____

On average, how many pad changes are required in 24 hours? _______# of pads

PELVIC PAIN SECTION: _____ NOT APPLICABLE

If you are currently experiencing pain, please rate your pain on a 0-10 scale with 10 being the worst.
(circle): 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Where is your pain?____
Describe the nature of the pain (burning, ache)____
Frequency of pain (constant, intermittent)_______________________________________
Do you take medications for this pain?____
When do you experience pain or a worsening of your pain?_____________________________
____

Do you have tingling or numbness? Yes/No

PROLAPSE SECTION: _____ NOT APPLICABLE

Rate a feeling of **organ "falling out"** or heaviness/pressure in perineum

___None present but doctor said it is an issue.
___Times per month (specify if related to activity or your period)
___With standing for __________ minutes or ___________hours.
___With exertion or straining
___Other

MEDICATIONS: Please list or provide a list of current medications.

Bladder and Bowel Record

Name:______________________________ Date:_____________

Record in appropriate column:

Column 1: Record length of time of urine flow in seconds or record the volume in ounces.
Column 2: Indicate bowel movement in toilet: **D** for Diarrhea, **F** for formed stool, **C** for constipated or too firm stool.
Column 3: Indicate **L** for large or **S** for small accident.
Column 4: Note the reason that you may have had an accident, i.e., sneezed, coughed, lifted something heavy, too far from bathroom, etc.
Column 5: Place a check next to the time you changed or put on a pad for urine loss.
Column 6: Record what you drink and amount in ounces.

Time Interval	Urinated in toilet	Bowel **D**, **F**, or **C**	Accident L or **S**	Reason for Accident	Changed Pad	Liquid intake in oz
6 am						
7						
8						
9						
10						
11						
12 Noon						
1 pm						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12 midnight						
1am						
2						
3						
4						
5 am						

Comments: Any unusual occurrences during the day, i.e. traveling, less active, more active, party or alcohol use, etc. ____

____

Bladder and Bowel Record

Name:______________________ Date:__________

Record in appropriate column:

Column 1: Record length of time of urine flow in seconds or record the volume in ounces.
Column 2: Indicate bowel movement in toilet: **D** for Diarrhea, **F** for formed stool, **C** for constipated or too firm stool.
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8						
9						
10						
11						
12 midnight						
1am						
2						
3						
4						
5 am						

Comments: Any unusual occurrences during the day, i.e. traveling, less active, more active, party or alcohol use, etc. ____

____