Functionize Health & Physical Therapy

Pelvic Floor Consent Form and Questionnaire

Patient Name:	Date:
Briefly describe your current complaint:	
When did this problem begin?	
How is it changing? (Circle) Getting: BETTER WORSE NO CHANGE	
Rate your feeling as to the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10 0 = No problem at all 10 = Worst problem imaginable	

Do you now have or do you have a history of the following?

- ☐ Bladder infections
- ☐ Pelvic pain
- ☐ Low back pain
- ☐ Childhood bladder problems
- ☐ Trouble holding gas
- ☐ Constant dribbling of urine
- ☐ Interstitial cystitis
- ☐ Constipation
- ☐ Joint problems
- ☐ Abdominal pain
- ☐ Sexually transmitted diseases
- ☐ HIV/AIDS
- ☐ Fecal incontinence
- ☐ Blood in urine
- ☐ Bladder cancer
- ☐ Painful penetration
- ☐ Painful periods
- ☐ "Falling out sensation
- ☐ Erectile dysfunction
- ☐ Other:

Female & OB/GYN History			
Number of: Pregnancies: Live Births: Vaginal deliveries: C-Sections: Episiotomies/Tearing:			
Difficult or complicated childbirth? (Circle) YES NO			
If yes, please describe:			
Birthweight of largest baby:			
Date of last pap smear:			
Pelvic Surgeries? (Please describe)			
Menopause? Yes NO		Date of last period:	
Do you have frequent urinary tract infections? YES NO		Do you have frequent yeast infections? YES NO	
Fluid Intake			
Intake per day: (one glass = 8 ounces or 1 cup) (Circle)	0-1	2-3	4-5 >5
Number of caffeinated glasses per day: (Circle)	0-1	2-3	4-5 >5
Number of alcoholic glasses per day: (Circle)	0-1	2-3	4-5 >5
Bowel and Bladder Habits			
Number of times you urinate during the day? (Circle)	3-5	6-9	10-12 >13
Number of times you urinate after going to bed? (Circle)	0-1	1-2	2-3 >3
Number of bowel movements per day? (Circle)	0-1	1-2	2-3 >3
Number of bowel movements per week? (Circle)	1-4	5-9	9-12 >12
Consistency of stools: (Check) ☐ Liquid ☐ Soft ☐ Normal ☐ Firm ☐ Pellets			
Bladder / Bowel Questions:			

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Does your bladder feel full after urination?	YES	NO	Do you empty your bladder frequently, before the urge?	YES	NO
Can you stop the flow of urine?	YES	NO	Do you ignore the urge to defecate?	YES	NO
Do you strain to pass urine?	YES	NO	Do you strain to pass feces?	YES	NO
Do you have a slow, hesitant urine stream?	YES	NO	Do you have "triggers" that make you need to urinate?	YES	NO
Do you have burning sensation with urination?	YES	NO	Do you take laxatives / enemas regularly?	YES	NO

Urinary / Fecal Leakage Questions:						
Number of urinary leakages daily:	1	2	3	4	5	
Number of fecal/bowel leakages daily:	1	2	3	4	5	
Severity of leakage? (Circle)	None	Few drops		Wets underwear		Wets outerwear
Protection worn:	None	Mini pad		Maxipad		Full undergarment

"Leakage occurs with…" (Check all that apply)	☐ Activity	☐ Strong urge to go
	☐ Changing positions	☐ Sexual activity
	☐ Walking to toilet	☐ Exercise
	☐ Cough / sneeze / laugh	☐ No activity changes leakage (constant)
	☐ Hear running water	☐ Other:
Pelvic Pain Questions:		
"I have pain with…" (Check all that apply)	☐ Sexual activity	☐ Standing
	☐ Penetration	☐ Tight clothes
	☐ Urination	☐ Menstruation
	☐ Defecation	☐ Delaying urination
	☐ Sitting	☐ Tampon use
	☐ Orgasm	☐ Pelvic exam
	☐ Ejaculation	☐ Pap smear
		☐ Other:
"Pain is located…" (Check all that apply)	☐ Vagina	☐ Anus
	☐ Clitoris	☐ Rectum
	☐ Labia (outer lips)	☐ Perineum (area between anus & vagina/scrotum)
	☐ Penis – Tip	
	☐ Penis – Shaft	☐ Entire pelvic region
	☐ Scrotum	☐ Tailbone / Coccyx
	☐ Testicles	☐ Tailbone / Sacrum
	☐ Urethra	☐ Pubic bone
		☐ Other:
Pain is: (Check all that apply)	☐ Deep	☐ Surface
	☐ Right side	☐ Left side
	☐ Both sides	☐ Constant

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. I understand that to evaluate and treat my condition it may be necessary, initially and periodically, to have my physical therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length. I understand that no guarantees have been or can be provided regarding the success of therapy. I hereby request and consent to the evaluation and treatment to be provided by the physical therapists of Functionize Health.

Signed: Dated: