Santa Maria Valley
PHYSICAL THERAPY GROUP

Tom Meenzhuber PT  Todd Martin PT  Samantha Stollberg PT, GCS  Jared Bailey PT
Karen Bailey PT  John Hollinshead PT  Marcelle Andaya, DPT

Please fill out the enclosed forms and bring them with you to your first appointment. At that time, we will do a brief examination of your pelvic floor muscles, and you are welcome to bring someone with you if that would make you more comfortable. Your appointment will take place in a private room. If you have any questions prior to the appointment, please feel free to contact us at (805) 928-8257.

Sincerely,

Samantha Stollberg PT + Karen Bailey PT

Samantha Stollberg, P.T. and Karen Bailey, P.T.

820 East Enos Drive  Santa Maria,CA 93454  (805) 928-8257  Fax (805) 349-7206  www.smvpt.com

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# CONSENT FOR EVALUATION AND TREATMENT OF PELVIC FLOOR DYSFUNCTION

I acknowledge and understand that I have been referred to Santa Maria Valley Physical Therapy Group 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, and vulvar 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 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. I understand that this evaluation and/or treatment could potentially elicit pain or discomfort.

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. Treatment may also include _____ _____.

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

Date_____Patient Name:_____
(Please Print)

_____
Patient Signature

_____
Signature of Parent or Guardian (if applicable)

_____
Witness Signature

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

**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 brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder
Y/N Surgery for your prostate
Y/N Surgery for your abdominal organs
Other/describe_____

Ob/Gyn History (females only)

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

Bladder /Bowel

Y/N Trouble initiating urine stream
Y/N Childhood bladder problems
Y/N Constant dribbling of urine
Y/N Blood in urine
Y/N Urinary hesitancy/slow stream
Y/N Trouble feeling bladder urge/fullness
Y/N Dribbling after urination
Y/N Other/describe_____
Y/N Trouble emptying bladder completely
Y/N Recurrent bladder infections
Y/N Constipation/straining for movement
Y/N Trouble holding back gas/feces
Y/N Trouble feeling bowel/urge/fullness
Y/N Difficulty stopping the urine stream
Y/N Straining or pushing to empty bladder

**Explain all yes responses**_____

| Medication | Start date | Reason for taking |
|---|---|---|
| | | |
| | | |
| | | |

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# SYMPTOM QUESTIONNAIRE

Name _____ Date_____

1. Describe your main problem _____
_____

2. When did your bowel or bladder problem first begin?__months ago or____years ago

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date_____ _____
_____

4. Since that time is it: staying the ___ same ___ getting worse ___ getting better.
Why or how?_____

5. Frequency of urination: awake hours _____times per day, sleep hours __ times per night.

6. 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

7. The usual amount of urine passed is: ___small ___ medium___ large.

8. Frequency of bowel movements ___ times per day, ___ times per week, or _____.

9. 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

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

11. Rate a feeling of organ "falling out" or pelvic heaviness/pressure:
___None present
___Times per month (specify if related to activity or your period)
___With standing for ___ minutes or ___hours
___With exertion or straining
___Other_____

Skip to question #16 if no leakage.

12a. Bladder leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

12b. Bowel leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion

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13a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

13b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

14. What form of protection do you wear? (Please complete only one)
___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
Other_____

15. On the average, how many pad changes are required in 24 hours?_____# of pads.

16. Activities/events that cause your symptoms. Check all that apply
___ Strong urge to go
___ Walking to the toilet
___ Changing positions (example - sit to stand)
___ No activity changes the problem
___ With cough/sneeze/ laugh /yell
___ Vigorous activity or exercise (running, weight lifting, jumping)
___ Light activity (walking, light housework)
___ Sexual activity
___ Other, please list_____

17. How has your lifestyle/quality of life been altered or changed because of this problem? Please respond to all that apply.
___Social activities (exclude physical activities), specify_____

___Diet /Fluid intake, specify _____

___Physical activity, specify _____

___Work, specify _____

___Other_____

18. Rate your feelings as to the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____.