



Todd Martin PT Jared Bailey PT Samantha Stollberg PT, GCS
Tom Meenzhuber PT John Hollinshead PT John Hinds PT
Karen Bailey PT Adrian Asencio OT R/L, CHT

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, GCS
Karen Bailey PT



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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 Inc. 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 palpitation of 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 a vaginal sensory for muscle biofeedback. I understand that this evaluation and/ or treatment could potentially elicit pain or discomfort, but can be stopped at anytime if I request so.

Treatment may include, but not limited to the following: observation, palpitation, 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 an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists Karen Bailey, PT and/ or Samantha Stollberg, PT, GCS

Patient Name: _____ Date: _____
(please print)

Signature: _____

Signature of Parent/ Guardian if applicable): _____

Witness Signature: _____



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HEALTH SCREENING QUESTIONNAIRE

Name: _____ Date: _____ Age: _____

Check of any/ all of the specific problems or conditions you now have or have ever had. Explain all responses that are checked and include the date problem began.

MEDICAL HISTORY

- High Blood Pressure _____
- Diabetes _____
- Neurological _____
- Multiple Sclerosis _____
- Stroke _____
- Head Injury _____
- Allergies _____
- Latex Sensitive _____
or allergy _____
- Smoking habit _____
- Other _____

- Cancer _____
- Asthma _____
- Emphysema _____
- COPD _____
- Heart Disease _____
- Broken bones _____
- Joint problems _____
- Low back pain _____
- Siatica _____
- Sexually _____
Transmitted Disease _____
- HIV/ AIDS _____

Date of last pelvic/ prostate exam _____

Date of last urinalysis _____

Other tests _____

SURGICAL HISTORY

- Back/ spine _____
- Brain _____
- Female organs _____
Other please explain _____

- Bladder _____
- Prostate _____
- Abdominal organs _____
Other please explain _____

OB/ GYN HISTORY

- Childbirth vaginal deliveries # _____
- Episiotomy # _____
- C- Section # _____
- Difficult Childbirth # _____
- Pelvic organ prolapse _____
Other please explain _____

- Vaginal Dryness _____
- Painful periods _____
- Menopause _____
- Painful vaginal penetration _____
- Pelvic pain _____



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HEALTH SCREENING QUESTIONNAIRE (CONTINUED)

BLADDER/ BOWEL HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Trouble initiating urine stream _____ | <input type="checkbox"/> Trouble emptying bladder completely _____ |
| <input type="checkbox"/> Childhood bladder problems _____ | <input type="checkbox"/> Recurrent bladder infections _____ |
| <input type="checkbox"/> Constant dribbling of urine _____ | <input type="checkbox"/> Constipation/ straining for movement _____ |
| <input type="checkbox"/> Blood in urine _____ | <input type="checkbox"/> Trouble holding back gas/ feces _____ |
| <input type="checkbox"/> Urine hesitancy/ slow stream _____ | <input type="checkbox"/> Trouble feeling bowel/ urge/ fullness _____ |
| <input type="checkbox"/> Trouble feeling bladder urge/ fullness _____ | <input type="checkbox"/> Difficulty stopping the urine stream _____ |
| <input type="checkbox"/> Dribbling after urination _____ | <input type="checkbox"/> Straining or pushing to empty bladder _____ |
| Other please describe _____ | |

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 _____ 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 the 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-# of episodes _____ No leakage _____ Times per week _____ Times per month _____ Only with physical exertion/ cough	12b. Bowel leakage-# of episodes _____ No leakage _____ Times per week _____ Times per month _____ Only with physical exertion
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13a. On average, how much urine do you leak? _____ No leakage _____ Just a few drops _____ Wets underwear _____ Wets outerwear	13b. How much stool do you loose? _____ No leakage _____ Stool staining _____ Small amount in underwear _____ Complete emptying
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14. What form of protection do you wear? (Please complete only one)
 _____ None
 _____ Minimal protection (Tissue paper/ paper towel/ panty shields)
 _____ Moderate protection (absorbent product, maxi pad)
 _____ Maximum protection (Specialty product/ diaper)

15. On 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-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 the problem?
 Please respond to all that apply.

_____ Social activities (exclude physical activity) 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. _____