INFORMATION ON PHYSICAL THERAPY TREATMENT
FOR PELVIC FLOOR DYSFUNCTION AND BLADDER/BOWEL PROBLEMS

IMPORTANT—READ IMMEDIATELY

Your first appointment will take 45 to 60 minutes, so please plan your time appropriately. Please allow enough time for parking and registration. If you are 15 minutes late to your appointment, you may need to reschedule.

Your appointment is scheduled for ___________ AM/PM on ______________________________ with ___________________________ located at 2238 Geary 7th floor NW.

Please register for your appointment at the Ob/Gyn registration desk on the 7th floor SW.

Enclosed please find:
1. Symptom and Health Screening questionnaires
2. Keeping a Record of Your Bladder Function
3. Daily voiding logs
4. Biofeedback for the Pelvic Floor Muscles information
5. Consent for Evaluation and Treatment of Pelvic Floor Dysfunction

All these forms must be completed prior to your appointment Begin the voiding logs now.

• Be sure to read the directions for KEEP A RECORD OF YOUR BLADDER FUNCTION carefully so your logs are as accurate as possible.
• Incomplete information may delay your evaluation and treatment.
• While we understand that not everyone feels that they have a bladder or bowel problem, your physical therapist can often times learn a lot about your pelvic floor dysfunction by looking at your completed log. Your completed log includes information on your voiding and nutritional habits which may be affecting your symptoms.
• Menstruation is NOT a reason to cancel your appointment. Please come to this appointment even if you have started your period unless you really are not feeling well.

The office evaluation of your condition may include:
• A screening of your low back and hip
• External and internal vaginal examination of your pelvic floor muscles.
• Measurement of your pelvic floor muscle function with biofeedback equipment using stick-on external sensors or an internal sensor inserted vaginally. These instruments record your muscle activity and help evaluate and treat your pelvic floor muscles.
• Exercise instruction for pelvic floor and other muscle groups as indicated.

Return visits for therapy will be scheduled at regular intervals to measure your progress and modify your exercise program as needed. These appointments are important in order to progress your treatment program. Take care in scheduling your appointments because if you need to reschedule it may delay the timing of your next session. Please feel free to invite someone to accompany you to your appointments if doing so will make you feel more comfortable.

If you have any questions or needed to cancel/reschedule your appointment, please telephone your physical therapist:
(Dorothy) Jane Walter, PT (415) 833-2428
Alexis Anderson, PT (415) 833-7040
Yvette Fawzi, PT (415) 833-4246
1. Describe your main problem

2. When did your symptoms 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 or 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?

7. The usual amount of urine passed is: _____ small _____ medium _____ large.

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

9. 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.

10. 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 #15 if no leakage.**

11. Bladder leakage—number of episodes
    _____ No leakage
        _____ Times per day
        _____ Times per week
        _____ Times per month
        _____ Only with physical exertion/cough

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

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

15. Activities/events that cause you 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

16. 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

17. Rate your feelings as to the severity of this problem from 0-10 with 0 being no problem and 10 being the worst __________
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 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 abdominal organs

Other/describe _______________________________________________________________________

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #_____ Y/N Vaginal dryness
Y/N Episiotomy # _____ Y/N Painful periods
Y/N C-Section # _____ Y/N Menopause – when? ______
Y/N Difficult childbirth # _____ Y/N Painful vaginal penetration
Y/N Prolapse or organ falling out Y/N Pelvic Pain
Y/N Other/describe _________________________________________________________________

Bladder/Bowel

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

Explain all yes responses _____________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Medication      Start date      Reason for taking
__________________  _______________  __________________
__________________  _______________  __________________
__________________  _______________  __________________
**KEEPING A RECORD OF BLADDER FUNCTION**

The main purpose of a bladder log is to document how your bladder functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns. At first, the log is used as an evaluation tool. Later, it will be used to measure your progress on bladder retraining or leakage episodes. **Please complete a bladder log every day for _____ days and bring it with you to your appointment.**

Your log will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of the day exactly what happened in the morning.

**INSTRUCTIONS**

**Column 1 – Time of Day**
The log begins with midnight and covers a 24 hour period. Afternoon times are in bold. Select the hour block that corresponds with the time of day you are recording information.

**Column 2 – Type & Amount of Fluid & Food Intake**
- Record the type and amount of fluid you drank
- Record the type and amount of food you ate
- Record when you woke up for the day and the hour you went to sleep

**Column 3 – Amount Voided (Urinated): Three methods**
Record the time of day and amount voided. Use the first method unless directed by your health care provider to directly measure or count urine amounts. Record a bowel movement with a BM at the appropriate time.

1. Place an S, M, L, in the box at the corresponding time interval each time you urinate.
   - S - SMALL=seemed like a small amount, or urinated “just in case”.
   - M - MEDIUM=seemed like an 8 ounce measuring cup would run over.
   - L - LARGE=seemed like the amount you urinate when you first wake up in the morning.
2. If you have difficulty gauging the amount of urine, you may record seconds by counting “one-one thousand” (this equals one second) while emptying your bladder. Record the total number of seconds it took you to void.
3. Measure urine amounts with a collection device. The best method is a collection “hat” that can be placed directly over the toilet. Ask your provider where to get one. Some people use 2-4 cup measuring containers, but it is sometime difficult to catch the urine in these. Record the measured ounces of urine in the box at the corresponding time interval each time you urinate.

**Column 4 – Amount of Leakage**
Record the amount of urine loss at the time it occurred.
- S - SMALL= drop or two of urine
- M - MEDIUM=wet underwear
- L - LARGE=wet outwear of floor

**Column 5 – Was Urge Present**
Describe the urge sensation you had as:
- 1- MILD=first sensation of need to go
- 2- MODERATE=stronger sensation to go
- 3- STRONG=need to get to toilet, move aside!

**Column 6 – Activity with Leakage**
Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, bent over, lifted something or had a strong urge.

**Comments** – (at the bottom of the log table) Special problems and new or changes in medication are recorded here. If a pad change was needed record the number used during the day at the bottom of the page.
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<tr>
<th>Time of Day</th>
<th>Type &amp; Amount of Food &amp; Fluid Intake</th>
<th>Amount Voided in Ounces or S/M/L or seconds</th>
<th>Amount Leakage S/M/L</th>
<th>Was Urge Present 1/2/3</th>
<th>Activity With Leakage</th>
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Comments: week before period_________________________ Number of pads: ______
## DAILY VOIDING LOG

Name ___________________________    Date _______________

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Comments ___________________________________________________________________

Number of pads used today __________________
# Daily Voiding Log

**Name ___________________________**  
**Date _______________**

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Comments ___________________________________________________________________

Number of pads used today ___________________
WHAT IS BIOFEEDBACK?
Biofeedback, also called Surface Electromyography (SEMG), is a learning technique that utilizes specialized equipment to assist a person in gaining control of their natural body functions. It involves the monitoring of a life process (bio) and the return of that information to the patient and therapist in a meaningful form (feedback).

Biofeedback training uses sensitive equipment that enables you to see or hear how your muscles are responding to your instructions. Becoming aware of these responses is the first step in learning to control them. By combining this information with special exercises, you can learn to relax tense muscles or strengthen weak muscles.

WHO USES BIOFEEDBACK?
Your health care provider has recommended biofeedback evaluation and treatment for the muscles of your pelvic floor. These muscles are responsible for bladder and bowel control as well as sexual response. Anyone interested in learning how to relax tense muscles, strengthen weak ones, or to control and coordinate use of muscles may benefit from biofeedback.

WHAT DOES THE EVALUATION INVOLVE?
For the evaluation you will use either an internal sensor, placed into the vagina or rectum, or external stick-on sensors placed around the rectal opening. These sensors are used to monitor the muscle activity of your pelvic floor. This enables you and your therapist to see and evaluate resting muscle activity as well as evaluate your muscle strength and endurance. The results of your evaluation will help your therapist design a specific treatment plan for your needs.

WHAT IS REQUIRED AFTER THE EVALUATION?
Your exercise program will depend upon the results of your evaluation. Almost everyone is asked to carry out a home exercise program utilizing the skills and exercises they learn in the clinic. Some people need special home biofeedback equipment to help them monitor their exercise program. If this is necessary for you, the equipment can be either rented or purchased. Your therapist will guide your treatment program, which usually takes 2 – 8 visits to the clinic.

Please feel free to ask us any more information on biofeedback and its uses.
CONSENT FOR EVALUATION AND TREATMENT
OF PELVIC FLOOR DYSFUNCTION

I acknowledge and understand that I have been referred to the Kaiser Permanente Urogynecology/Physical Therapy Department for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include but are not limited to urinary incontinence, difficulty with bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, and vulvar or pelvic 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 and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal 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 instructions.

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 therapist and therapy assistants and technicians of Kaiser Permanente.

Date ________________  Patient Name:__________________________________
(Please Print)

____________________________________
Patient Medical Record Number

____________________________________
Patient Signature

_____________________________________ Signature of Parent or Guardian (if applicable)

______________________________________ Witness Signature