



Women's Health Physical Therapy Appointment

Frequently Asked Questions

Your Physical Therapy appointment in the Women's Health Department

What can I expect?

First, you will have a physical examination to identify pelvic floor and postural muscle dysfunction by:

- A screening of the low back and hip.
- An external and internal evaluation of the pelvic floor muscles.

Next: A treatment plan will be designed to reduce pain and restore function

Your personalized plan may include one or more of the following:

1. Treatment
2. Muscle re-education
3. Muscle stretching
4. Exercises
5. Posture and body mechanics training
6. Biofeedback evaluation and training
7. Relaxation training

How will I remember all this?

You will be given written instructions for your individualized home exercise plan.

How long is this appointment?

Evaluation and follow-up appointments are one-hour in length.

Should I come alone?

- You are welcome to bring an adult friend or family member with you to the appointment.
- *We recommend children do not come to your appointment.*

What is expected of you?

- Please complete the "Physical Therapy Questionnaire" given to you by your physician and bring it to your Physical Therapy appointment.
- You are expected to come to all scheduled appointments. Failure to do so may result in your being discharged from the program.

How do I get an appointment?

To book, cancel or reschedule, please call:

925-295-6173

We look forward to working with you,
Mary Russell, PT and Kathleen West, PT

What if I'm bleeding?

Menstruation is NOT a reason to cancel your appointment. Please come to this appointment even if you have started your period.



Women's Health Physical Therapy Questionnaire

Name: _____ Kaiser Number: _____
Age: _____ Referring Provider: _____

Please complete and bring this questionnaire to your appointment. Thank you.

What is the problem you wish to talk to the physical therapist about today?

1. On a scale of 1 to 10, what is your pain? _____
2. How long have you had this problem? _____ weeks/months/years
3. Have you been treated for this problem in the past? YES / NO
If yes, when? _____
4. Are you currently taking medications for this problem? YES / NO
If yes, what? _____
5. Are there activities you notice that aggravate this problem? YES / NO
If yes, what? _____
6. Are there activities you notice that ease this problem? YES / NO
If yes, what? _____
7. Do symptoms vary with your menstrual cycle? YES / NO
8. Are symptoms relieved by voiding your urine? YES / NO
9. Do you have pain with sexual activity? YES / NO
If yes, since your **first sexual experience** or with your **current partner**? (Circle one)
10. Do you have a history of unpleasant or unwanted sexual experience? YES / NO
11. Do you have pain with a pelvic exam (pap smear)? YES/NO
12. Are you able to use a tampon? YES / NO / DO NOT USE

BLADDER HABITS

1. What is your daily fluid intake?
 - Water: _____
 - Coffee/Tea: _____
 - Soda (Regular or Diet): _____
 - Alcohol: _____
2. How often do you urinate every day? _____
3. How often do you get up at night to urinate? _____
4. Do you have urinary urgency? YES / NO
5. Do you have urinary leakage? YES / NO
6. Do you have pain when you urinate? YES / NO

BOWEL HABITS

1. Do you have leakage? YES / NO
2. Do you have difficulty defecating? YES / NO
3. Do you have constipation? YES / NO
4. Do you have diarrhea? YES / NO
5. Do you have pain with defecation? YES / NO

Name: _____

Kaiser Number: _____

OB/GYN History

1. At what age did you start your menstrual cycle? _____
2. Are your cycles regular? YES / NO
3. Do you usually have cramping or pain with your menses? YES / NO
4. Is there any sexually transmitted disease (STD) history? YES / NO
If yes, please explain: _____
5. How many pregnancies have you had? _____
6. Out of those pregnancies, how many deliveries have you had? _____
 How many were C-Sections? _____
 How many were vaginal? _____
 Were there any complications? _____
7. Out of those pregnancies, how many abortions have you had? _____
8. Out of those pregnancies, how many miscarriages have you had? _____
9. How many tubal pregnancies have you had? _____
10. How many living children do you have? _____

General Health

1. Do you smoke? YES / NO
If yes, how many packs a day? _____
2. What do you do for recreational activities/exercise?

3. What is your occupation? _____

4. What are 3 activities that you have difficulty with as a result of your problem?

Score from 0 (unable to perform) to 10 (able to perform at pre-injury level)

- | | |
|--------------------------------|--------------|
| <input type="checkbox"/> _____ | SCORE: _____ |
| <input type="checkbox"/> _____ | SCORE: _____ |
| <input type="checkbox"/> _____ | SCORE: _____ |

5. What are your goals for treatment?

What can you expect during a Physical Therapy appointment?

- Appointments are 1 (one) hour long.
- An initial evaluation to identify pelvic floor and postural muscle dysfunction may include:
 - o A musculoskeletal screening of the low back and hip range of motion and strength.
 - o An external and internal evaluation of the pelvic floor muscles.
 - This may be performed vaginally, rectally and/or with biofeedback.
- You will receive a treatment plan designed to reduce pain and restore function.
- You will be given written instructions for an individualized home exercise plan.
- Menstruation is NOT a reason to cancel your appointment.** Please come to this appointment even if you have started your period.
- If you need to cancel or reschedule your appointment, please call: 925-295-6173
- Please be careful when scheduling follow-up appointments as it is difficult to rebook in a timely manner and your treatment may be delayed.**

We look forward to working with you! Mary Russell, PT and Kathleen West, PT