Name:
Date:

URINARY SYMPTOMS

Do you experience frequent urination?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

Do you experience a strong feeling of urgency to empty your bladder?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

Do you experience nighttime urination?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

How many times do you awaken to urinate during a typical night?

Do you experience bedwetting?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

URINARY INCONTINENCE

Do you leak urine?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

If yes:

Does this interfere with your normal activities?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

How long have you had urinary incontinence? _____ Months/Years

Is your incontinence getting worse?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

For how long?_____ Months/Years

Do you tie your incontinence to any of the following?

Childhood ☐ Pregnancy ☐ Delivery ☐ Medication ☐ Surgery ☐ Menopause ☐

Please mark any of the following boxes that describe the circumstances associated with your incontinence:

Stress Incontinence		***Urge Incontinence***		***Unconscious Incontinence***	
Cough/Sneeze		Stand up		Without stress or urge	
Bend/Stand		Running water		Continuous leak	
Lift		Bathroom door		Unaware of leak	
Exercise		Riding in door		Bedwetting	
Walk		Sexual intercourse			

Referring to the above table, indicate what percentage of your incontinence occurs with each category:

Type of Incontinence	**%**
Stress Incontinence	
Urger Incontinence	
Unconscious Incontinence	

How many times do you leak in an average week? _____

Do you wear protection for your incontinence: _____
If yes:

Do you wear them during the: Day % Night % Both %

Please indicate if you have tried any of the following therapies for your incontinence:

Use	**Product**	**Number per week**
	Mini-pad	
	Panty liner	
	Maxi-pad	
	Adult diaper	

Please indicate if you have tried any of the following therapies for your incontinence:

General		Medications		Surgery	
Pelvic muscle exercises		*Ditropan (Oxybutinin)*		*Vaginal surgery*	
Retraining drills		*Tofranil (Imipramine)*		*Abdominal surgery*	
Biofeedback		*Detrol (tolterodine)*		*Sling surgery*	
Electrical stimulation		*Other*		*Other*	

Please estimate how much of the following beverages you drink each day:
cup = 8oz pint = 16 oz quart = 32 oz soda can = 12 oz

Type of Beverage	Amount (oz)
Caffeinated	
Non-caffeinated	
Alcoholic	

VOIDING DYSFUNCTION

Do you experience difficulty emptying your bladder?
None Minimally Moderately Severely

Do you have difficulty initiating flow?
None Minimally Moderately Severely

Do you have a weak or prolonged flow?
None Minimally Moderately Severely

How often do you have intermittent flow?
None Minimally Moderately Severely

How often do you have a sense that you do not completely empty your bladder?
None Minimally Moderately Severely

How often do you have pain during urination?
None Minimally Moderately Severely

How often do you have to change position to completely empty your bladder?
None Minimally Moderately Severely

How often do you have dribbling after you have finished urinating?

None ⬜ Minimally ⬜ Moderately ⬜ Severely ⬜

Do you have problems with urinary tract infections?

None ⬜ Minimally ⬜ Moderately ⬜ Severely ⬜

How many urinary tract infections have you had in your lifetime? _____

How many urinary tract infections have you had this year?_____

Date of last infection _____

PROLAPSE SYMPTOMS

Do you experience lower abdominal pressure?

None ⬜ Minimally ⬜ Moderately ⬜ Severely ⬜

Do you experience heaviness in the pelvic area?

None ⬜ Minimally ⬜ Moderately ⬜ Severely ⬜

Do you experience bulging or protrusion you can see in the vaginal area?

None ⬜ Minimally ⬜ Moderately ⬜ Severely ⬜

Do you experience pelvic discomfort when standing or physically exerting yourself?

None ⬜ Minimally ⬜ Moderately ⬜ Severely ⬜

Please indicate if you have tried any of the following therapies for your prolapse:

General		**Surgery**	
Pelvic muscle exercises		*Vaginal surgery*	
Pessary		*Abdominal surgery*	
Other		*Combined surgery*	

BOWEL SYMPTOMS

How many bowel movements do you typically have per week? _____ Per month?

_____

Please indicate if you have been diagnosed with any of the following:

Irritable bowel syndrome		*Crohns disease*	
Diverticulosis		*Ulcerative colitis*	
Diverticulitis		*Levator spasm*	
Hemorrhoids		*Colonic inertia*	

How often are you bothered by diarrhea?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

ANAL INCONTINENCE

Do you leak stool?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

If yes:

Do you leak liquid stool?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

Do you leak solid stool?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

Does this interfere with your normal activities:

None ☐ Minimally ☐ Moderately ☐ Severely ☐

How long have you had anal incontinence? _____ months/years

Is your incontinence getting worse?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

For how long? _____ months/years

Do you tie your anal incontinence to any of the following?

Childhood ☐ Pregnancy ☐ Delivery ☐ Medication ☐ Surgery ☐ Menopause ☐

How many times do you leak in an average week? _____

DEFECATION DYSFUNCTION

How often are you bothered by constipation?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

How many years have you suffered from constipation?

None ☐ 1-5 ☐ 5-10 ☐ 10-20 ☐ >20 ☐

How often do you suffer from pain during a bowel movement?

None ☐ less than 25% of the time ☐ less than 50% of the time ☐ less than 75% of the time ☐ 100% ☐

How often do you feel that you have not completely evacuated your bowel after a bowel movement?
None ☐ less than 25% of the time ☐ less than 50% of the time ☐ less than 75% of the time ☐ 100% ☐

Do you ever use a finger to push in your vagina or on your bottom to help evacuation?
None ☐ less than 25% of the time ☐ less than 50% of the time ☐ less than 75% of the time ☐ 100% ☐

Do you ever use a finger in your anus to help evacuation?
None ☐ less than 25% of the time ☐ less than 50% of the time ☐ less than 75% of the time ☐ 100% ☐

How many minutes do you typically spend in the bathroom for your bowel movement?
<5 ☐ 5-10 ☐ 10-20 ☐ 20-30 ☐ >30 ☐

How many unsuccessful attempts at bowel movement do you have in 24 hours?
None ☐ 1-3 ☐ 3-6 ☐ 6-9 ☐ >9 ☐

Please indicate products that you have tried to improve your bowel function:

Metamucil (psyliium)		*Milk of Magnesia (magnesium hydroxide)*	
Citrucel (methylcelluose)		*Ex-Lax (phenolphthalein)*	
Colace (ducusate sodium)		*Dulcolax (bisacodyl)*	
Surfak (docusate calcium)		*Chronulac (lactulose)*	
Peri-colace (docusate/casanthronol)		*GoLytely (polyethelene glycol)*	
Fleets enemas		*Senna (senokot)*	
Magnesium citrate		*Other -*	

PELVIC PAIN
Do you have pelvic pain? yes / no

If yes:

Does this interfere with your normal activities?
None ☐ Minimally ☐ Moderately ☐ Severely ☐
How long have you had pelvic pain? _____ months/years

Is it getting worse?
None ☐ Minimally ☐ Moderately ☐ Severely ☐
For how long has your pelvic pain been getting worse? _____ months/years

Do you tie your pelvic pain to any of the following?

Childhood ☐ Pregnancy ☐ Delivery ☐ Medication ☐ Surgery ☐ Menopause ☐
Eating ☐ Urination ☐ Bowel movements ☐ Intercourse ☐ vaginal infection ☐

SEXUAL FUNCTION

Do you have sexual relations? yes / no

If no:

How long have you abstained from sexual relations? _____ months/years

Do you tie your abstinence to any of the following?

Childhood ☐ Pregnancy ☐ Delivery ☐ Medication ☐ Surgery ☐ Menopause ☐
Spouse ☐ Lack of spouse ☐

If yes:

Do you experience painful intercourse?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

How does this affect your frequency of intercourse?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

If you experience painful intercourse:

Is it painful at the time of insertion?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

Is it painful with deep penetration?

None ☐ Minimally ☐ Moderately ☐ Severely ☐

How do the following affect your sexual relations?

	None	Minimally	Moderately	Severely
Spouse limitations				
Urinary incontinence				
Prolapse				
Anal incontinence				
Pelvic pain				
Pain with intercourse				

CONSENT FOR EVALUATION AND TREATMENT FOR FEMALE PELVIC FLOOR DYSFUNCTION

I acknowledge and understand that I have been referred to Zion Physical Therapy, PC for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunction include but are not limited to urinary and fecal incontinence, difficulty with bowel, bladder or sexual functions, persistent sacroiliac or low back pain, and/or chronic rectal region pain.

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 muscles and tissue surrounding the vagina and rectum. Internal vaginal or rectal exams may be required to assess pelvic floor dysfunction. This evaluation will assess skin conditions, reflexes, muscle tone, length, strength and endurance, as well as scar mobility and function of the pelvic floor region. Such evaluation may include trigger point localization and or vaginal or rectal sensor usage for muscle biofeedback. I understand that this evaluation and/or treatment could potentially elicit pain or discomfort.

Treatment may include, but may not be limited to the following: observation, palpation, use of 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 information.

I understand that no guarantees have been or can be provided regarding the success of therapy. I will inform my therapist of any condition that would limit my ability to participate in therapy and/or any concerns I may have regarding internal vaginal and/or rectal exams. I hereby request and consent to the evaluation and treatment to be provided by the therapists of Zion Physical Therapy, PC.

Date_____ Patient Name: _____

Patient Signature_____

Signature of Patient or Guardian_____
(if applicable)

Witness Signature_____ _____