Zion
PHYSICAL
THERAPY

Pelvic Floor Therapy Questionnaire

Patient name _____ **Date** _____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____ Number of vaginal deliveries _____

Birth weight of largest baby _____ Number of cesarean deliveries _____

Number of episiotomies _____ Date of last pap smear _____

Did you have any trouble healing after delivery	Y	N			
Do you have a history of sexual abuse or trauma	Y	N	Received counseling?	Y	N
Are you having regular periods/ menstrual cycles	Y	N			
Do you have frequent urinary tract/yeast infections?	Y	N	How many this year?		
Have you tried pelvic floor PT in the past?	Y	N			

Pain

Do you have pain with:

Sexual intercourse	Y	N	If Y: Insertion / Penetration
Pelvic exam	Y	N	
Tampon use	Y	N	
Back pain	Y	N	
Leg pain	Y	N	
Groin Pain	Y	N	
Abdominal Pain	Y	N	
Pelvic Pain	Y	N	

Test results

Urological	Y	N	Results: _____
Bowel test	Y	N	Results: _____

Bladder symptoms

Do you lose urine when you:

Cough/ sneeze/ laugh	Y	N	Lift/ exercise/ dance/ jump	Y	N
On the way to the bathroom	Y	N	Have a strong urge to urinate	Y	N
Hear running water	Y	N	Other _____	Y	N

Do you wet the bed	Y	N		
Have burning/ pain with urination	Y	N		
Difficulty starting a stream of urine	Y	N		
Strain to empty your bladder	Y	N		
Feel unable to empty bladder fully	Y	N		
Have a falling out feeling	Y	N		
Wear a pessary	Y	N		
Have pain with a full bladder	Y	N		
Have an urgency of urination (a strong urge to urinate)	Y	N		
Urinate more than 7 times/day	Y	N		
Get up at night to use the bathroom	Y	N	If yes, how often?	_____
Wear protection for incontinence	Y	N	How much/day?	_____

How much of the following do you drink:

Water:	A little	Medium	A lot
Coffee/Tea:	A little	Medium	A lot
Alcohol:	A little	Medium	A lot
Other: ____	A little	Medium	A lot

Bowel symptoms

Strain to have a bowel movement	Y	N	Leak / stain feces	Y	N
Include fiber in your diet	Y	N	Have diarrhea often	Y	N
Take laxatives / enema regularly	Y	N	Leak gas by accident	Y	N
Take a suppository	Y	N	Use a finger in vagina/anus to evacuate	Y	N
Use supplements	Y	N			
Have pain with bowel movement	Y	N			
Have a very strong urge to move your bowels	Y	N			

How often do you move your bowels: _____ per day, week

Most common stool consistency

____ liquid ___ soft ___ firm ___ pellets ___ other _____

Thank you for taking the time to fill out this questionnaire.

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_____ _____