PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred 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; 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/or palpating 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 vaginal or rectal sensors for muscle biofeedback.

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 instruction.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I have the option of having a second person present in the room during the procedure and _____ choose _____ refuse this option.

Date: _____ Patient Name: _____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature

The Institute for
Female Pelvic Medicine
& Reconstructive Surgery®

Caring Specialists. Restoring Pelvic Support. Curing Incontinence.

PELVIC FLOOR DISTRESS INVENTORY

NAME _____ DATE _____

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas but please fill out both sides of this form as completely as possible.

Urinary Distress Inventory 6 (UDI-6)

Do you experience, and, if so, how much are You bothered by	Not at all	Somewhat	Moderately	Quite a bit
Usually experience frequent urination?				
Usually experience urine leakage associated with a feeling of urgency, this is, a strong sensation of needing to go to the bathroom?				
Usually experience urine leakage related to coughing, sneezing, or laughing?				
Usually experience small amounts of urine leakage (that is, drops)?				
Usually experience difficulty emptying your bladder?				
Usually experience pain or discomfort in the lower abdomen or genital region?				

Colorectal-Anal Distress Inventory 8 (CRADI-8)

Do you experience, and, if so, how much are You bothered by	Not at all	Somewhat	Moderately	Quite a bit
Feel you need to strain too hard to have a bowel movement?				
Feel you have not completely emptied your bowel at the end of a bowel movement?				
Usually lose stool beyond your control if your stool is well formed?				
Usually lose stool beyond your control if your stool is loose?				
Usually lose gas from the rectum beyond your control?				
Do you usually have pain when you pass your stool?				
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?				
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?				

Reviewed with Patient _____/____/____
Drs Initials & Date

Please complete other side →

NAME ____ DATE ______________

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you experience, and, if so, how much are You bothered by	Not at all	Somewhat	Moderately	Quite a bit
Usually experience pressure in the lower abdomen?				
Usually experience heaviness or dullness in the pelvic area?				
Usually have a bulge or something falling out that you can see or feel in your vaginal area?				
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?				
Usually experience a feeling of incomplete bladder emptying?				
Ever have to push up on the bulge in the vaginal area with your fingers to start or complete urination?				

Pelvic Floor Impact Questionnaire

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feeling. For each question place an **X** in the response that best describes how much you're activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months.** Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions relate to the following →→→ Usually affect your ↓	***Bladder or Urine***	***Bowel or Rectum***	***Vagina or Pelvis***
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. Ability to travel by car or bus for a distance greater that 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. Participating in social activities outside your home>	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. Emotional health (nervousness, depression, etc)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Reviewed with Patient ____________/____/____
Drs Initials & Date

Gyn/Ob History:

Number of pregnancies	
Number of vaginal deliveries Number of cesarean deliveries	
Number of episiotomies	
Birth weight of the largest baby	
If you are currently pregnant how many weeks and are there any medical concerns with this pregnancy?	
Did you have trouble healing after the delivery?	
Do you have regular periods/menstrual cycles	
Do you have frequent urinary tract infections?	
Any history of sexually transmitted disease/infections?	
Have you had any pelvic/abdominal surgeries?	
Do you have IBS/ cystitis / endometriosis?	

Do you have pain with:

Sexual intercourse	
Pelvic exam	
Urination	
Bowel movement	
Do you have pain in the back/legs/groin/abdomen?	