SAUNDERS THERAPY CENTERS

FEMALE PELVIC DYSFUNCTION QUESTIONAIRE

Name: _____ Date:_____

**Do you now have or have you had a history of the following?** Explain 'yes' responses and include dates.

**Y/N** Abdominal pain
**Y/N** Joint problems
**Y/N** Allergies
**Y/N** Low back /sciatica
**Y/N** Bladder cancer
**Y/N** Pelvic pain
**Y/N** Bladder infections
**Y/N** Pelvic trauma
**Y/N** Blood in urine
**Y/N** Sensitivity to latex
**Y/N** Broken bones
**Y/N** Sexual/ physical abuse
**Y/N** Childhood bladder problems
**Y/N** Sexually transmitted disease
**Y/N** Constant dribbling of urine
**Y/N** TMJ
**Y/N** Constipation
**Y/N** Trouble emptying bladder
**Y/N** Fecal incontinence
**Y/N** Trouble feeling bladder fullness
**Y/N** Fibromyalgia
**Y/N** Trouble holding back gas
**Y/N** Irritable Bowel Syndrome
**Y/N** Trouble initiating urine stream
**Y/N** Other (please list) _____
Explain 'yes' responses: _____
_____
_____

**Surgical History:**

**Y/N** Surgery for your back/spine
**Y/N** Surgery for bladder
**Y/N** Surgery for your brain
**Y/N** Surgery for abdominal organs
**Y/N** Surgery for your female organs
**Y/N** Other type please describe _____

**OG/GYN History:** Explain 'yes' responses and include dates.

**Y/N** Painful periods
**Y/N** Fibroids
**Y/N** Painful penetration
**Y/N** D&C procedure
**Y/N** Pregnancies #_____
**Y/N** Endometriosis
**Y/N** Vaginal deliveries #_____
**Y/N** Cysts
**Y/N** C-section # _____
**Y/N** Vaginal Dryness
**Y/N** Episiotomy/ Tears # _____
**Y/N** Pelvic inflammatory disease
**Y/N** Difficult childbirth
**Y/N** Unusual discharge
**Y/N** Uterine/rectal/bladder prolapsed
**Y/N** Perimenopause
**Y/N** Prolapse or falling out feeling
**Y/N** Menopause (date of last period)
Explain 'yes' responses: _____
_____
_____

**Diagnosis specific to current problem not already indicated:** _____
_____

| **Medications:** | **Start date:** | **Reason for taking:** |
|---|---|---|
| _____ | | |
| _____ | | |
| _____ | | |

**Bladder Habits**

1. Are you unable to stop the flow of urine when on the toilet? **Y/N**
2. Is it difficult to tell when you need to go to the toilet? **Y/N**
3. Do you strain to pass urine? **Y/N**
4. Do you empty your bladder before you experience the urge to urinate? **Y/N**
5. Do you have difficulty completely emptying your bladder? **Y/N**
6. Do you have difficulty initiating the stream of urine? **Y/N**
7. Do you have triggers that make you feel you cannot wait to use the toilet? **Y/N**
8. Do you have pain or burning with urination? **Y/N**
9. Do you have pain or discomfort when you wipe yourself? **Y/N**
10. Do you leak more during, before or after your period? **Y/N**

**Bowel Habits**

1. Are you unable to feel that you need to have a bowel movement or pass gas? **Y/N**
2. Do you strain to have a bowel movement? **Y/N**
3. Do you feel your rectum is not completely empty after a bowel movement? **Y/N**
4. Do you have difficulty initiating a bowel movement? **Y/N**
5. Do you have pain or burning with bowel movements? **Y/N**
6. Do you have a history of hemorrhoids? **Y/N**
7. Have you experienced a change in you bowel habits? **Y/N**
   If 'yes' please describe: _____
8. Do you take anything to help you pass stool? **Y/N**
   If 'yes' please list: _____
9. Do you have difficulty holding back gas? **Y/N**

**Pelvic Floor Symptoms**

1. Are you sexually active? **Y/N**
2. Do you have pain with intercourse or penetration? **Y/N**
3. Do you have pain with use of tampons? **Y/N**

**BLADDER AND BOWEL SYMPTOM QUESTIONNAIRE**

Name: _____ Date: _____

1. How often do you urinate during the day? _____times, at night? _____ times.
2. How often do you have a bowel movement? _____times/ day/ week?
3. How often do you experience bowel /bladder leakage? **(please circle all that apply)**
   Never less than daily daily throughout the day nighttime/sleep
4. What is the amount of leakage? **(please circle all that apply)**
   No leakage soils pad or underwear soils outerwear
   How many do you use per day? _____
5. What type of protection do you wear? **(please circle all that apply)**
   None pantiliner maxi pad specialty product other
6. What causes you to leak? **(please circle all that apply)**
   Vigorous activity (running, aerobics)
   Light activity (walking, light house work)
   Cough/ sneeze
   Walking to the toilet
   Strong urge to go
   Intercourse or sexual activity
   Other _____
7. How long can you delay the need to urinate? **(please circle all that apply)**
   Not at all 1-5 min 5-10 min 10-30 min 30+min
8. How much fluid do you drink each day (one glass = 8 oz or one cup)
   _____ Total glasses of liquid per day
   _____ # of caffeinated glasses per day
   _____ # of alcoholic beverages per day
9. Rate your feelings as to severity of this problem from 0- 10, 10 being the worst.
   0_____10

Additional Comments: _____

_____

_____

SAUNDERS
THERAPY CENTERS

# CONSENT FOR EVALUATION AND TREATMENT

I understand that my physician has referred me to physical therapy for evaluation and treatment of pelvic floor dysfunction, and it may be beneficial for my therapist to perform a *muscle assessment of the pelvic floor*. Palpation of these muscles is most direct and accessible if done via the vagina and/ or rectum.

I understand that if I am uncomfortable with the assessment or treatment procedures at any time, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me. I understand that I may refuse any part of the treatment plan that I am uncomfortable with.

I understand that at any time I may request to have another person present during the evaluation and treatment.

I herby request and consent to the evaluation and treatment to be provided by the physical therapist.

Patient Name (please print): _____

Patient Signature: _____

Signature of Parent or Guardian (if applicable): _____

*** *If you are pregnant, have infections of any kind, have vaginal dryness, are less that 6 weeks post partum or post surgery, have severe pelvic pain, sensitivity to KY jelly, vaginal creams or latex, please inform the therapist prior to pelvic floor assessment.*