INFORMED CONSENT for ASSESSMENT AND TREATMENT OF THE PELVIC FLOOR

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. I understand that it may be beneficial for my therapist to perform soft tissue assessment and treatment of the pelvic floor. Palpation of this area is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain, urinary or fecal incontinence, difficulty with bowel, bladder, or sexual functions, dyspareunia (pain with intercourse), pain from episiotomy or scarring, vulvodynia, vestibulitis, or other similar conditions. Restrictions in this area may also be contributing to symptoms in other areas of your body.

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 biofeedback. I understand that the benefits of this procedure will be explained to me. I understand that, if I am uncomfortable with this treatment procedure AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

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.

This direct pelvic floor release procedure utilizes myofascial release principles entailing the relaxation and lengthening of muscles, fascia and other soft tissue structures within the areas of the pelvic floor, sacrum, coccyx, and the sacroiliac, hip and pubic joints. The procedure also requires pressure and/or distraction directly to the coccyx bone. This technique is an accepted physical therapy technique, as indicated above. Our experience has demonstrated that this direct pelvic floor release is helpful, often facilitating consistent therapeutic results. As with any area of the body, most people require a series of these specific treatments. This is determined by your evaluation and treatment findings.

I have read and understand fully and consent to the above procedure being performed by the therapists at the Outpatient Therapy Dept.

Patient's Printed Name_____ Date_____

Patient's Signature_____

Witness Signature_____

*** If you are pregnant, have infections of any kind, have vaginal dryness, are less than 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 this procedure.

WALLACE PHYSICAL
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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 the appointment.

History

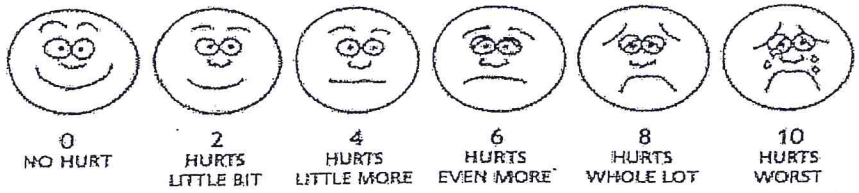
Number of pregnancies _____ Number of vaginal deliveries _____
Birth weight of largest baby _____ Number of cesarean deliveries _____
Number of episiotomies _____ Date of last pap smear _____

Did you have any trouble healing after delivery?	Y	N
Do you have a history of sexual abuse or trauma?	Y	N
Are you having regular periods/menstrual cycles?	Y	N
Do you have frequent urinary tract infections?	Y	N

Pain

Do you have pain with:

Sexual intercourse	Y	N
Pelvic exam	Y	N
Tampon use	Y	N
Back, leg, groin, abdominal pain	Y	N



Test Results

Urodynamic tests	Y	N	Results:
Cystoscope	Y	N	Results: _____
Urine test	Y	N	Results:
Bowel test	Y	N	Results: _____

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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
Hear running water	Y	N
Have a strong urge to urinate	Y	N
Other _____	Y	N

Do you:

Wet the bed	Y	N
Have a burning / pain with urination	Y	N
Have difficulty starting a stream of urine	Y	N
Strain to empty your bladder	Y	N
Feel unable to empty the bladder fully	Y	N
Have a falling out feeling	Y	N
Have pain with a full bladder	Y	N
Have a strong urge to urinate	Y	N
Urinate more then 7 times per day	Y	N

Bowel Symptoms

Do you:

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
Have pain with a bowel movement	Y	N
Have a very strong urge to move your bowels	Y	N

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

Most common stool consistency

_____ liquid _____ soft _____ firm _____pellets _____other_____

**Thank you for taking the time to fill out this questionnaire!

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Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel.

Today's Date: _____

		0	1	2	3	4
1	How many times do you go to the bathroom during the day?	3 to 6	7 to 10	11 to 14	15 to 19	20+
2	a. How many times do you go to the bathroom at night?	0	1	2	3	4+
	b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe	
3	Are you currently sexually active?	Yes	No			
4	a. **IF YOU ARE SEXUALLY ACTIVE,** do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always	
	b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always	
5	Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always	
6	Do you have urgency after going to the bathrrom?	Never	Occasionally	Usually	Always	
7	a. If you have pain, is it usually...		Mild	Moderate	Severe	
	b. Does your pain bother you?	Never	Occasionally	Usually	Always	
8	a. If you have urgency, is it usually...		Mild	Moderate	Severe	
	b. Does your urgency bother you?	Never	Occasionally	Usually	Always	

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