

Information on Physical Therapy for Pelvic Floor Muscle Dysfunction

You have scheduled an appointment for evaluation and treatment of a pelvic floor issue.

Following, you will find a pelvic floor questionnaire and a bladder diary along with instructions for filling out the diaries. Please fill out 1-2 days of the diary. The questionnaire and diaries give your therapist necessary information about your bladder and pelvic floor muscle function, which is very helpful in the evaluation and treatment process. Please bring these completed diaries with you to your 1st appointment (If you run out of time to complete the diaries before your appointment, do not cancel your appointment. They can be completed for a future appointment).

The evaluation of your pelvic floor muscles by the physical therapist may include:

1. Observation of your perineum/rectal area.
2. Internal evaluation of your pelvic floor muscles.
3. Exercise instructions for the pelvic floor and abdominal muscles.

Return visits to the physical therapist will be scheduled at regular intervals to measure your progress and modify your exercise program as needed.

Please feel free to invite someone to accompany you to your physical therapy appointments if doing so will make you feel more comfortable.

If you have any questions please call (260) 483-9933.

MEN'S HEALTH PHYSICAL THERAPY QUESTIONNAIRE

Name: _____

What are we seeing you for? _____

When did your symptoms start? _____

What do you think caused your symptoms? _____

How many physicians have you seen regarding this problem? _____

Have you had surgery that directly relates to your symptoms? _____

On a scale of 0 to 10 (0=No effect, 10= Severe impairment), how much is your problem affecting your quality of life?

Any history of sexual abuse?	Yes	No
Do you have pain with sexual intercourse	Yes	No
Are you able to attain an erection?	Yes	No
Are you able to ejaculate?	Yes	No
Do you have pain, urinary/bowel symptoms during/after ejaculation?	Yes	No
History of STD's current _____ or past _____? If past, cure date _____		
Do you have frequent urinary tract infections?	Yes	No
Do you urinate more than once every 2 hours?	Yes	No
Do you have sense of "urgency" to urinate	Yes	No
Do you leak urine with coughing____, sneezing____, exercise____, lifting____, on the way to the bathroom____, sound of running water____?		
Amount of urine loss during above mentioned: small____, medium____, large____, continuous dribbling____?		
Do you use protective devices for urine loss?	Yes	No
Do you have difficulty stopping urine stream?	Yes	No
Do you experience burning/pain before, during, after urination?	Yes	No
Do any behaviors aggravate your urinary symptoms?	Yes	No
Does anything (position, dietary changes) improve your urinary symptoms? Explain: _____	Yes	No
Is your urine stream weak or interrupted?	Yes	No
How many times do you urinate at night?	1	2 3 4 5+
Do you have trouble starting or stopping urine stream?	Yes	No
How many times do you urinate during the day?	1	2 3 4 5+
# of caffeinated/carbonated beverages per day?	1	2 3 4 5+
# of glasses of water per day?	1	2 3 4 5+
# of alcoholic beverages per day?	1	2 3 4 5+
Have you ever taken medicine to prevent urine loss?	Yes	No
Do you leak gas____ or feces____?	Yes	No
Do you have constipation?	Yes	No
Are you currently taking any stool softeners or laxatives?	Yes	No
Do you have anal fissures or hemorrhoids?	Yes	No
Is your stool liquid____, soft____, firm____, hard____?		
How often do you have a bowel movement? _____ time(s) per day, every other day____, every 4-7 days____?		
What percentage of the time do you strain to evacuate? _____%		

KEEPING A RECORD OF YOUR BLADDER FUNCTION:

HOW TO KEEP YOUR BLADDER DIARY

The main purpose of a bladder diary is to document your bladder function. A diary can give your healthcare provider an excellent picture of your bladder function, habits, and patterns. The diary is initially used as an assessment tool. Later, it is used to measure your progress. Please complete your bladder diary every day for 1-2 days and bring it with you to your first appointment.

In the beginning, continue to go about your daily life as normal. You are making a written record of your normal bladder patterns, so please avoid making any changes in your bladder routines. The amount voided can be measured with a special urine collection "hat" available at medical supply stores, or using a standard measuring cup. If you cannot measure, estimate small, medium, or large amount. Your diary will be much more accurate if you fill it out as you go through the day.

If possible, remember to change your pad or clothing whenever you feel yourself leaking or notice you are damp. A dry pad or pair of underwear helps to increase your awareness of leakage.

INSTRUCTIONS:

*Write in the type and amount of drink in the appropriate time slots in the "DRINKS" column.

*The number of times you empty your bladder per day is recorded in the "URINE" column. Use checks to indicate the number of times you void. Write in the number of ounces you measured or circle your best estimate.

*In the "**ACCIDENTAL LEAKS**" column, circle the amount any time you leak. Indicate in the last column what activity you were doing at that time.

EACH SHEET HAS 2 SIDES and covers one 24-hour period. If you have any questions, please call (260) 483-9933 and ask for any of the therapists.

		ACCIDENTS							
Time	Drinks	Urine	Accidental leaks	Did you feel a strong urge to go?	What were you doing at the time?				
	What kind? How much?	How many times? How much? (circle one)	(circle one)	Circle one	Sneezing, exercising, having sex, lifting, etc.				
Sample			sm med lg	Yes No	Laughing				
7-8 p.m.	Soda 2 cans	✓	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					
8-9 p.m.			<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					
9-10 p.m.			<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					
10-11 p.m.			<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					
11-12 midnight			<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					
12-1 a.m.			<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					
1-2 a.m.			<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					
2-3 a.m.			<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					
3-4 a.m.			<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					
4-5 a.m.			<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					
5-6 a.m.			<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes No					

I used _____ pads. I used _____ diapers today (write number).

Questions to ask my health care team: _____