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.

PELVIC FLOOR QUESTIONNAIRE

Name_____

Physician_____ **Date**_____

Please describe your main problem:

_____

_____

When did it begin? _____

Is it getting BETTER, WORSE, or STAYING THE SAME? (circle one)

Please describe activities or things that you cannot do because of your problem:

_____

_____

Please list all pelvic and abdominal surgeries with dates of operation:

_____

_____

Date of last pelvic examination: _____ **Date of last urinalysis:** _____

Special Tests Performed: _____**Type:**_____ **Date:** _____

1. **Occurrence of incontinence or leakage (If this does not apply skip to question #7):**
   - Never (6)
   - Less than 1/month (5)
   - More than 1/month (4)
   - Less than 1/week (3)
   - More than 1/week (2)
   - Almost every day (2)
   - More than 1/day (0)

2. **Protection Worn**:
   - No Protection (4)
   - Pantishields (3)
   - Mini pad (2)
   - Maxi Pad (1)
   - Diaper/Serenity (0)

3. **Severity**:
   - No leakage (3)
   - Few drops (2)
   - Wet underwear (1)
   - Wet outerwear (0)

4. **Position or activity with leakage:**
   - Lying down
   - Sitting
   - Standing
   - Changing positions (from sit to stand)
   - Intercourse
   - Strong Urge

5. **How long can you delay the need to urinate?**
   - Indefinitely (6)
   - 1 + hours (5)
   - ½ hour (4)
   - 15 minutes (3)
   - Less than 10 minutes (2)
   - 1-2 minutes (1)
   - Not at all (0)

6. **Activity that causes urine loss:**
   - Vigorous activity (3)
   - Moderate activity (2)
   - Light activity (1)
   - No activity (0)
   - Type _____

7. **Prolapse (falling out feeling)**
   - Never (5)
   - Occasionally w/ menses (4)
   - Pressure @ end of day (3)
   - Pressure w/ straining (2)
   - Pressure w/ standing (1)
   - Perineal pressure all day (0)

8. **Frequency of urination (DAYTIME)**
   - 0 times per day
   - 1-4
   - 5-8
   - 9-12
   - 13+

9. **Frequency of urination (NIGHTTIME)**
   - 0 times per night
   - 1
   - 2
   - 3
   - 4+

10. **Fluid Intake: (includes water and beverages)**
    - 9+ 8 oz glasses per day
    - 6-8 8 oz glasses per day
    - 3-5 8 oz glasses per day
    - 1-2 8 oz glasses per day
    - How many caffeinated glasses? _____

11. **Frequency of bowel movements**
    - 2 times per day
    - 1 time per day
    - Every other day
    - Once every 4-7 days
    - Weekly
    - Other

12. **After starting to urinate, can you completely stop the urine flow?**
    - Can stop completely (3)
    - Can maintain a deflection of the stream (2)
    - Can partially deflect the urine stream (1)
    - Unable to deflect or slow the stream (0)

13. **Do you have trouble initiating a urine stream?**
    - Never (3)
    - More than 1/month (2)
    - Less than 1/week (1)
    - Almost every day (0)

14. **Attitude towards problem**
    - No problem (4)
    - Minor inconvenience (3)
    - Slight problem (2)
    - Moderate problem (1)
    - Major problem (0)

15. **Confidence in controlling your problem:**
    - Complete confidence (3)
    - Moderate confidence (2)
    - Little confidence (1)
    - No confidence (0)

16. **Are you sexually active? Yes_____ No_____**

    Are you pregnant or attempting pregnancy? Yes_____ No_____

    Number of pregnancies _____ Number of deliveries _____

    Complications:_____

17. **History of sexual abuse?** _____

18. **History of or present sexually transmitted diseases?**

_____

19. **Pain or problems with intercourse or urination:**_____

_____

20. **Have you ever been taught how to do pelvic floor KEGEL exercises? Yes_____ No_____**

    When: _____By **whom:** _____

21. **How often do you do pelvic floor exercises?**_____

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.

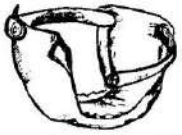
EACH SHEET HAS 2 SIDES and covers one 24-hour period. If you have any questions, please call (260) 483-9933 and ask for any of the therapists.

Your Daily Bladder Diary

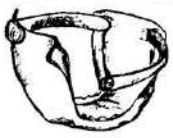
This diary will help you and your health care team. Bladder diaries help show the causes of bladder control trouble. The "sample" line (below) will show you how to use the diary.

Your name: _____

Date: _____

													
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)*			*How much? (circle one)*		*Circle one*		*Sneezing, exercising, having sex, lifting, etc.*		
Sample	Coffee	2 cups	✓✓	(sm)	med	lg	sm	(med)	lg	Yes	(No)	Running	
6–7 a.m.										Yes	No		
7–8 a.m.										Yes	No		
8–9 a.m.										Yes	No		
9–10 a.m.										Yes	No		
10–11 a.m.										Yes	No		
11–12 noon										Yes	No		
12–1 p.m.										Yes	No		
1–2 p.m.										Yes	No		
2–3 p.m.										Yes	No		
3–4 p.m.										Yes	No		
4–5 p.m										Yes	No		
5–6 p.m.										Yes	No		
6–7 p.m.										Yes	No		

ACCIDENTS

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

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

Questions to ask my health care team: _____

_____

_____

Let's Talk About Bladder Control for Women is a public health awareness campaign conducted by the National Kidney and Urologic Diseases Information Clearinghouse (NKUDIC), an information dissemination service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health.