PELVIC FLOOR PHYSICAL THERAPY 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.

5. I acknowledge that GBU requests 24 hours notice for appointment cancellations otherwise a $75.00 No-Show fee will be charged _____ (initial)

Date: _____ Patient Signature: _____

_____ _____

Patient Name Signature of Parent or Guardian (if applicable)

GREATER BOSTON UROLOGY™

NO SHOW/MISSED APPOINTMENT POLICY

We, at Greater Boston Urology, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 781-762-0471

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality of care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least 24-hours' notice: There may be a wait list for Physical Therapy services and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If the appointment is cancelled within 24- hours this will be documented as a " No-Show" appointment, you will be assessed a $75.00 No-Show fee.

3. If you do not present to the office for your appointment, this will be documented as a " No-Show" appointment, you will be assessed a $75.00 No-Show fee.

4. After any "No- Show/ Missed" appointment, you will receive a phone call and/or letter to reschedule this appointment and remind you of the "No-Show" policy.

5. If you have (3) "No-Show/Missed" appointments within a one-year time, you will be assessed a $100.00 "No-Show" fee. Greater Boston Urology may consider Dismissal from our Physical Therapy program. ***You will be notified by letter if the dismissal was approved.**

6. Patients with an outstanding balance of missed appointment fees will NOT be allowed to schedule another Physical Therapy appointment until the balance is paid in full.

I have read and understand Greater Boston Urology's "No-Show/ Missed" Appointment Policy and understand my responsibility to plan appointments accordingly and notify Greater Boston Urology appropriately if I have difficulty keeping my scheduled appointments.

_____	_____	_____
Patient Name	Date of Birth	Date
_____	_____	
Patient Signature or Parent/ Guardian if minor	Relationship to Patient	
_____	_____	
Staff Signature	Date	

Rev: 6/16/21

GREATER BOSTON UROLOGY™

NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

a.	Area between rectum and testicles (perineum)	□1 Yes	□2 No
b.	Testicles	□1 Yes	□2 No
c.	Tip of the penis (not related to urination)	□1 Yes	□2 No
d.	Below your waist, in your pubic or bladder area	□1 Yes	□2 No

2. In the last week, have you experienced:

a. Pain or burning during urination?	□1 Yes	□2 No
b. Pain or discomfort during or after sexual climax (ejaculation)?	□1 Yes	□2 No

3. How often have you had pain or discomfort in any of these areas over the last week?

□0 Never □1 Rarely □2 Sometimes □3 Often □4 Usually □5 Always

4. Which number best describes your AVERAGE pain or discomfort on the days you had it, over the last week?

NO PAIN □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 WORST IMAGINABLE

Urination:

5. How often have you had the sensation of not emptying your bladder completely after you finished urinating, over the last week?

□0 Not at all
□1 Less than 1 time in 5
□2 Less than half the time
□3 About half the time
□4 More than half the time
□5 Always

6. How often have you had to urinate again less than 2 hours after you finished urinating, over the last week?

□0 Not at all
□1 Less than 1 time in 5
□2 Less than half the time
□3 About half the time
□4 More than half the time
□5 Always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

□0 None
□1 Only a little
□2 Some
□3 A lot

8. How much did you think about your symptoms, over the last week?

□0 None
□1 Only a little
□2 Some
□3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last Week, how would you feel about that?

□0 Delighted
□1 Pleased
□2 Mostly satisfied
□3 Mixed (about equally satisfied and dissatisfied)
□4 Mostly dissatisfied
□5 Unhappy
□6 Terrible

SCORING (to be completed by provider)

Pain: (1a, 1b, 1c, 1d, 2a, 2b, 3, and 4) = _____
Urinary Symptoms: (5 and 6) = _____
Quality of Life Impact (7, 8, 9) = _____

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Pelvic Floor Physical Therapy - Patient History

Name _____ **DOB**_____ **Age**___ **Date**_____

1. Describe the current problem that brought you here?_____
   _____
2. When did your problem first begin?_____
3. Was your first episode of the problem related to a specific incident? Yes/No
   Please describe and specify date _____
   _____
4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
   Why or how?_____
5. If pain is present rate pain on a 0-10 scale 10 being the worst._____
6. Describe the nature of the pain (i.e. constant burning, intermittent ache)_____
   _____
7. Describe previous treatment/exercises_____
   _____

8. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than_____ minutes	___ With cough/sneeze/straining
___ Walking greater than ____minutes	___ With laughing/yelling
___ Standing greater than ___ minutes	___ With lifting/bending
___ Changing positions (ie. - sit to stand)	___ With cold weather
___ Light activity (light housework)	___ With triggers i.e. /key in door
___ Vigorous activity/exercise (run/weight lift/jump)	___ With nervousness/anxiety
___ Sexual activity	___ No activity affects the problem

___ Other, please list _____

9. What relieves your symptoms?_____
_____

10. How has your lifestyle/quality of life been altered/changed because of this problem?
    Social activities (exclude physical activities), specify_____
    Diet /Fluid intake, specify _____
    Physical activity, specify _____
    Work, specify _____
    Other _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____
11. What are your treatment goals/concerns?_____
_____

Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (unexplained tirednes
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling
Y/N	Other /describe_____		

Date of Last Physical Exam _____ Tests performed_____
_____

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Pg 2 History **Name** _____ **DOB ID#** _____ **Age** ___

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____
Mental Health: Current level of stress High_ Med___ Low___ Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Smoking history	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Irritable Bowel Syndrome	Depression
Acid Reflux /Belching	Hepatitis	Anorexia/bulimia
Joint Replacement	Sexually transmitted disease	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe_____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries #___	Y/N	Vaginal dryness
Y/N	Episiotomy #___	Y/N	Painful periods
Y/N	C-Section #____	Y/N	Menopause - when? ___
Y/N	Difficult childbirth #___	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic/genital pain_____

Y/N Other /describe_____

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation

Y/N Pelvic/genital pain location _____
Y/N Other /describe_____

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Pelvic Symptom Questionnaire

Y/N	Trouble initiating urine stream	Y/N	Blood in stool/feces
Y/N	Urinary intermittent /slow stream	Y/N	Painful bowel movements (BM)
Y/N	Strain or push to empty bladder	Y/N	Trouble feeling bowel urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Seepage/loss of BM without awareness
Y/N	Trouble emptying bladder completely	Y/N	Trouble controlling bowel urge
Y/N	Blood in urine	Y/N	Trouble holding back gas/feces
Y/N	Dribbling after urination	Y/N	Trouble emptying bowel completely
Y/N	Constant urine leakage	Y/N	Need to support/touch to complete BM
Y/N	Trouble feeling bladder urge/fullness	Y/N	Staining of underwear after BM
Y/N	Recurrent bladder infections	Y/N	Constipation/straining _____% of time
Y/N	Painful urination	Y/N	Current laxative use -type _____
Y/N	Other/describe _____		

Describe typical position for emptying: _____

1. Frequency of urination:
   Awake hours: _____ times per day **OR** every _____ minutes/hours (circle)
   Sleep hours _____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   _____minutes, _____hours, _____not at all
3. The usual amount of urine passed is: ___small ___ medium___ large
4. Frequency of bowel movements _____ times per day, _____times per week, or _____.
5. The bowel movements typically are: watery ___ loose ___ formed___ pellets ___ other _____
6. When you have an urge to have a bowel movement, how long can you delay before going to the toilet?
   _____minutes, ____hours, _____not at all.
7. If constipation is present describe management techniques _____
8. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
   Of this total how many glasses are caffeinated?_____ glasses per day.
9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
   ___None present
   ___Times per month (specify if related to activity or your menstrual period)
   ___With standing for _____ minutes or _____hours.
   ___With exertion or straining
   ___Other_____

10a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

10b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

11a. On average, how much urine do you leak?
___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

11b. How much stool do you lose?
___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying
___ Other _____

12. What form of protection do you wear? (Please complete only one)
___None
___Minimal protection (tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxi pad)
___Maximum protection (specialty product/diaper)

On average, how many pad/protection changes are required in 24 hours?
_____# of pads

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