HANSEN
PHYSICAL THERAPY
• Personal
• Professional
• Experienced Physical Therapy

50 E. Minnesota St. Ste. 2, Rapid City, SD 57701 • Phone (605) 342-3110 • Fax (605) 342-3120 • www.hansenphysicaltherapy.com

Dear Patient,

Thank you for choosing Hansen Physical Therapy for your pelvic health needs.

Ashley Hubregtse, DPT Physical Therapist specializing in pelvic health physical therapy, looks forward to meeting and getting to know you. Ashley has a passion to help people like you with a wide array of sensitive pelvic health problems. She is prepared and excited to help you help yourself improve your life.

What to expect at your appointment

At your initial appointment, you should expect:

1. To spend about 1 hour with Ashley in a private treatment room.
2. In-depth conversations regarding your chief complaint.
   Sensitive issues may be discussed in detail with the purpose of directing your care & providing you the best treatment possible. Your openness & honesty will be welcomed, encouraged & appreciated when at all possible.
3. Examination & evaluation of your pelvic floor.
   External examination &, possibly, internal evaluation of your pelvic area may be required for proper diagnosis & treatment. Your consent will be obtained before performing any type of evaluation &, as always in our clinic, you may cease the examination if you should become uncomfortable.
4. Development of a treatment plan
   A treatment plan will consist of a home exercise program; a variety of hands-on techniques performed in the clinic; & suggested frequency of follow up visits. Success in any treatment plan requires commitment from the patient & from the therapist.
5. Mutual respect & discretion in regard to anything discussed or observed.

I have included paperwork in this letter. Please fill out your paperwork prior to your appointment & BRING IT WITH YOU. I understand these forms are lengthy; however, your responses will be integral in directing your care. There may be some sections you can skip as they may not apply to you. For this reason, take your time & answer all questions as honestly as possible. Items you may feel are insignificant may be more pertinent to your treatment than you think.

Please call (605)342-3110 if you have questions or need to reschedule your appointment. We look forward to seeing you at your upcoming appointment!

Ashley Hubregtse, DPT, ATC

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Pelvic Floor History Form
Physical Therapy

NAME _____

CHIEF COMPLAINT

Describe the current problem that brought you here.

When did this problem begin? _____ Months ago _____ years ago

Since the onset, is your problem: Better Worse Same

Was your first episode of the problem related to a specific incident? Yes No

Date of incident _____
Describe incident.

Rate the severity of this problem.

0 1 2 3 4 5 6 7 8 9 10
No problem Major problem

Rate your pain.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain

Describe the nature of your pain (i.e. constant burning, intermittent ache, etc).

Describe how your lifestyle/quality of life been altered/changed by this problem? Please specify.

Physical activity:

Social activities:

Diet/Fluid intake:

Work:

Other:

Describe what relieves your symptoms.

Describe previous treatments/exercises.

What are your treatment goals/concerns?

Circle activities that cause or aggravate your **PAIN**. *If not applicable please go to next section.*

- Sitting more than ___ minutes
- Walking more than ___ minutes
- Standing more than ___ minutes
- Changing positions (i.e. sit-to-stand)
- Light activity (light housework)
- Vigorous activity/exercise (run/weight lift/jump)
- Sexual activity
- With cough/sneeze/straining
- With lifting/bending
- No activity affects my pain

Other, please list _____

Circle activities that cause or worsen your **LEAKING**.

- Constant leakage
- Sitting more than ___ minutes
- Walking more than ___ minutes
- Standing more than ___ minutes
- Changing positions (rolling, sit to stand)
- Light activity (walking, light housekeeping)
- Vigorous activity/exercise (running, weight lifting)
- Walking to the toilet
- Strong urge to go
- Sexual activity
- With cough/sneeze/straining
- With lifting/bending
- With laughing/yelling
- With cold weather
- With triggers – running water/key in door
- With nervousness/anxiety
- No activity affects my leakage

Other, please list _____

EMPLOYMENT HISTORY

Occupation: _____

Hours/week: _____

Missed work due to this problem? Yes No

HEALTH HISTORY

General Health: Excellent Good Average Fair Poor

Mental Health: Excellent Good Average Fair Poor

Current level of stress: High Med Low

Indicate yes or no below

Yes No Prostate disorders
If yes, describe?
_____

Yes No Shy bladder
Yes No Pelvic pain
Yes No Erectile dysfunction
Yes No Painful ejaculation

Describe other male health history not listed above.

Date of last physical exam: _____
Tests performed (please list):

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Type:

Circle any of the following conditions or diagnoses that apply to you.

- Allergies – list below
- Cancer
- Childhood bladder problems
- Chronic fatigue syndrome
- Depression
- Diabetes
- Epilepsy/Seizures
- Emphysema/Chronic bronchitis
- Fibromyalgia
- Headaches
- Heart problems
- Hepatitis
- High blood pressure
- HIV/AIDS
- Irritable bowel syndrome
- Joint replacement
- Kidney disease
- Latex sensitivity
- Low back pain
- Multiple sclerosis
- Osteoarthritis
- Osteoporosis
- Pelvic pain
- Physical or sexual abuse
- Rheumatoid arthritis
- Sacroiliac/Tailbone pain
- Sexually transmitted disease
- Stroke
- Thyroid problems
- TMJ/Neck pain

Other/Describe: _____

Have you had any of these symptoms in the past 6 months?

Yes	No	Fever/Chills
Yes	No	Unexplained weight change
Yes	No	Dizziness or fainting
Yes	No	Change in bowel or bladder functions
Yes	No	Malaise (Unexplained tiredness)
Yes	No	Unexplained muscle weakness
Yes	No	Night pain/Sweats
Yes	No	Numbness/Tingling

Circle all areas in which you have had surgeries or procedures.

Back/Spine	Bladder/Prostate
Brain	Bones/Joints
Female organs	Abdominal organs

Please provide date and type for all procedures circled above.

Medications (pills, injection, patch) Start Date Reason

_____

_____

_____

_____

Over-the-counter vitamins, etc Start Date Reason

_____

_____

_____

_____

BLADDER HEALTH

Indicate your average fluid intake (one glass is 8 oz or one cup) _____ glasses/day
Of this total how many glasses are caffeinated? _____ glasses/day

How often do you urinate?
Awake hours: _____ times/day Sleep hours: _____ times/night

Circle the typical amount of urine passed per urination: Small Medium Large

Indicate yes or no below in regards to your bladder habits.

Yes No Sensation that you need to go to the toilet?
If yes, how long can you delay the urge before you have to go to the toilet? _____minutes, _____hours, _____not at all

Yes No Urinate frequently BEFORE you have the urge to urinate?

Yes No Do "triggers" make you feel like you can't wait to go to the toilet?
If yes, describe (ie. running water)_____

Yes No Trouble making it to the toilet in time when you have the urge?

Yes No Take your time to go to the toilet and empty your bladder?

Yes No Difficulty initiating the urine stream?

Yes No Can you stop the flow of urine when on the toilet?

Yes No Slow/hesitant/intermittent urinary stream?

Yes No Strain to pass urine?

Yes No Pain when you urinate?

Yes No Blood in your urine?

Yes No Dribble after urination?

Yes No Feel your bladder is still full after urinating?

Yes No Have you had any bladder infections in the last year?
If yes, how many? _____Date of last infection? _____
If yes, treatment received? _____

Circle the form of protection you wear.

None Minipads Specialty product Other_____

Tissue paper Maxipads Diaper

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

Bladder leakages

Number of episodes
___ Not applicable
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/cough
___ Constant

On average, how much urine do you leak?
___ Not applicable
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floo

BOWEL HEALTH

How often do you have a bowel movement?

_____ times/day _____ times/week

Circle the consistency of your stool: Hard Loose Normal

Indicate yes or no in regards to your bowel habits.

Yes No Sensation that you need to have a bowel movement?
If yes, how long can you delay the urge before you have to go to the toilet? _____ minutes, _____ hours, _____ not at all

Yes No Ignore the urge to defecate?

Yes No Trouble making it to the toilet on time when you have an urge?

Yes No Strain to have a bowel movement?
If yes, how often? _____ % of the time

Yes No Pain when you defecate (have bowel movement)?

Yes No Leak gas?

Yes No History of constipation?
If yes, what are your management techniques?_____

Circle the form of protection you wear.

None Minipads Specialty product Other_____

Tissue paper Maxipads Diaper

On average, how many pad/protection changes are required in 24 hours for bowel leakage?

_____ # of pads

Bowel leakages

Number of episodes
- ___ Not applicable
- ___ Times per day
- ___ Times per week
- ___ Times per month
- ___ Only with exertion/strong urge
- ___ Constant

How much stool do you lose?
- ___ Not applicable
- ___ No leakage
- ___ Stool staining
- ___ Small amount in underwear
- ___Complete emptyin

SEXUAL HISTORY

Indicate yes or no below.

Yes No History of sexual abuse.

Yes No Sexually active.
If not applicable please go to next section.

Yes No Pain with intercourse.

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PELVIC FLOOR 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 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, postural restoration 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 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 procedure.
4. Second person in room.

   _____ I choose to have a second person present in the room during the examination

   _____ I decline having a second person present in the room during the examination.

   _____ I am okay with a student OBSERVING during the examination.

_____
Patient Name

_____ _____
Patient signature Date

_____ _____
Signature of patient or Guardian (if applicable) Date

_____ _____
Physical Therapist signature Date