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 Patients and Parent/Guardian,

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

Ashley, physical therapist specializing in pelvic health physical therapy, looks forward to meeting & getting to know you. She has a passion to help people like you with a wide array of sensitive pelvic health problems. She is prepared & excited to help you learn how to actively 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 pelvic floor concerns.
   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.
   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.
   Visual inspection of your low back, hips, and abdomen.
   External examination your pelvic area may be required for proper diagnosis & treatment.
   Internal evaluation will not be performed on anyone under the age of 18 without parent and doctor consent along with patient consent if able.
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.

We have included paperwork in this letter. <u>Please fill out your paperwork prior to your appointment & BRING IT WITH YOU.</u> We understand these forms are lengthy; however, the accuracy of your responses will be important 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

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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, trauma 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 physical 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 programs 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 Parent or Guardian (if applicable) Date

_____ _____
Physical Therapist Signature Date

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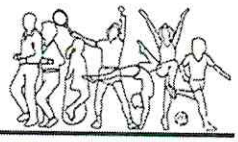

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Pediatric History Form
Physical Therapy

NAME _____

**If possible please have patient & parent/guardian fill out paperwork together.*

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 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).

How often does this problem affect you?
Daily Weekly Monthly Other

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**. *If not applicable please go to next section.*

- 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 school/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		

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

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	Pantyshields	Maxipads	Diaper
Tissue paper	Minipads	Specialty product	Other_____

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 floor

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	Pantyshields	Maxipads	Diaper
Tissue paper	Minipads	Specialty product	Other_____

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 emptying

HOW DO YOU IDENTIFY

Male
Female
Other

Male transitioning to female
Female transitioning to male

OBSTETRIC & GYNECOLOGIC HISTORY *If not applicable please go to next section.*

Indicate yes or no below

Yes No Vaginal dryness

Yes No Regular periods.

How frequent? _____

If no, why?_____

Yes No Painful periods.

Yes No Painful vaginal penetration.

Yes No Pelvic pain.

Yes No Prolapse or organ falling out.

If yes, circle all that apply:

Only with menstruation
With standing for ____ minutes or _____ hours
With exertion or straining
At the end of each day
Present all day

Describe other obstetric or gynecologic history not listed above.

MALE HISTORY

Date of last physical exam: _____

Yes No Prostate disorders

If yes, describe? _____

Shy bladder Yes/ No

Pelvic Pain Yes/No

Erectile dysfunction Yes/No

Painful ejaculation Yes/ No

Describe other male health history not listed above.

Tests performed (please list):

CHILDBIRTH HISTORY

Indicate yes or no below.

Yes No Pregnancies. #_____

If no, please disregard remaining questions.

Yes No Childbirth vaginal deliveries. #_____

Yes No Episiotomy. #_____

Yes No Painful episiotomy scar.

Yes No C-section. #_____

Yes No Difficult childbirth. #_____

Yes No Labor trauma.

If yes, describe: _____

Indicate birth weights/dates of babies.

Date	Weight
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

SEXUAL HISTORY

Indicate yes or no below.

Yes No History of sexual abuse.

Yes No Sexually active.

Yes No Pain with intercourse.