

INFORMATION ON TREATMENT FOR PELVIC FLOOR DYSFUNCTION AND BLADDER / BOWEL PROBLEMS

IMPORTANT – READ IMMEDIATELY

Your first appointment will take 45 to 90 minutes so plan your time appropriately. Please arrive at least 15 minutes early to complete necessary paperwork.

Your appointment is scheduled for _____ a.m./p.m. on _____

Enclosed please find:

1. **HISTORY AND SCREENING QUESTIONNAIRES**
2. **KEEPING A RECORD OF YOUR BLADDER FUNCTION**
3. **DAILY VOIDING LOG.**

All these forms must be completed prior to your first appointment.

- Begin the voiding log now.
- Be sure to read the directions for **KEEPING A RECORD OF YOUR BLADDER FUNCTION** carefully so your log is as accurate as possible.
- Incomplete information may delay insurance processing and authorization for subsequent treatment.
- Prior to your first appointment we recommend you check with your insurance company regarding coverage for treatment.

The office evaluation/treatment of your condition may include:

- Review of your history.
- Measurement of your pelvic floor muscle function with biofeedback equipment. These instruments record your muscle activity and help evaluate and treat your pelvic floor muscles.
- Musculoskeletal and pelvic floor muscle exam.
- Exercise instruction for pelvic floor and other muscle groups as indicated.

Return visits for therapy will be scheduled at regular intervals to measure your progress and modify your exercise program as needed. These appointments are important in order to progress your treatment program.

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

If you have any questions, please telephone 360-573-3611.

INFORMED CONSENT FOR ASSESSMENT OF PELVIC FLOOR DYSFUNCTIONS.

I understand that if I am referred to physical therapy for pelvic floor dysfunction, it may be beneficial for my therapist to perform a *muscle assessment of the pelvic floor*, initially and periodically to assess muscle strength, length, range of motion and scar mobility. Palpation of these muscles is most direct and accessible if done via the rectum. Pelvic floor dysfunctions' include pelvic pain syndromes, urinary incontinence, scarring, proctalgia/prostatitis or other similar complications. Evaluation of my condition may include observation, soft tissue mobilization, use of rectal sensors for biofeedback and/or electrical stimulation.

I understand that the benefits of the rectal assessment will be explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternative will be discussed with me.

Treatment procedures for pelvic floor dysfunctions' include, without limitation, education, exercise, stimulation, ultrasound, use of weights, and several manual techniques including massage, joint and soft tissue mobilization. The therapist will explain all these treatment procedures to me and I may choose to not participate with all or part of the treatment plan. I understand that no guarantees have been or can be provided to me regarding the success of therapy.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment.

Based on the information I have received for the therapist, I voluntarily agree to standard assessment and muscular treatment techniques of the perineal area.

Patient's Signature & Date

Therapist's Signature & Date

Patient's Legal Representative/Guardian/Parent

Relationship to Patient

NAME _____
 DATE _____ Initial Visit Discharge Visit

CONDITION (CHECK ALL THAT APPLY)

- (A) Bladder incontinence (C) Bowel incontinence (E) Pelvic/perineal pain
 (B) Urinary urgency/frequency (D) Fecal urgency (F) Other

ACUITY

(Answer on initial visit.)
 How long ago did onset of symptoms occur? _____

FUNCTION

To what degree does your condition interfere with your participation in the following activities: (if you have bowel or bladder problems, rate interference when you are NOT using a pad or leakage protection).

	Never Interferes	10-20% of the time	30-40% of the time	50-60% of the time	70-80% of the time	Always Interferes
1. Household Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Physical Activity/Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Intimate Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sitting through long events (more than 3 hours)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Work Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Activities without bathroom access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sleep (# times/night your sleep is interrupted)	<input type="checkbox"/> 0x	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5+x
9. Number absorbent products used per day to manage your condition	<input type="checkbox"/> 0x	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5+x

10. PLEASE INDICATE TYPE OF PROTECTION USED

- (A) none (D) medium flow pad
 (B) tissue/paper towels (E) heavy flow pad
 (C) panty liner (F) specialty pad/protective garment

11. Number of bowel/urine leakage accidents per 24 hours? _____
 12. Frequency of daytime urination? _____
 13. Frequency of nighttime urination? _____

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below



PLEASE COMPLETE ON LAST VISIT ONLY

IMPROVEMENT INDEX

Please indicate the amount of improvement you have made since the beginning of your treatment on the scale below.



I am aware that the information gathered on this form may be used anonymously for research or publication.
 (Please Initial) _____

HOW DIET CAN AFFECT YOUR BLADDER

Although there is no particular "diet" that can cure bladder control, there are certain dietary suggestions you can use to help control the problem.

There are 2 points to consider when evaluating how your habits and diet may affect your bladder;

1. Foods and Fluids that that can irritate the bladder

Some foods and beverages are thought to contribute to bladder leakage and irritability. However their effect on the bladder is not completely understood and you may want to see if eliminating one or all of these items improves your bladder control. If you are unable to give them up completely, it is recommended that you use the following items in moderation:

- Foods with acidic properties:
- Alcoholic beverages
- Tomato based products
- Vinegar
- Coffee (regular and decaf)
- Tea (regular and decaf)
- Curry
- Spicy foods
- Caffeinated beverages
- Carbonated beverages
- Cola
- Milk
- Food colorings and flavorings
- Artificial sweeteners
- Chocolate

Substitutions for Bladder Irritants

Although water is always the best beverage choice, grape and apple juice are thirst quenchers and are not as irritating to the bladder.

Low acid fruits: pears, apricots, papaya, watermelon

For coffee drinkers: KAVA®
Postum®
Pero®
Kaffree Roma®

For tea drinkers: Non-citrus herbal Sun brewed tea

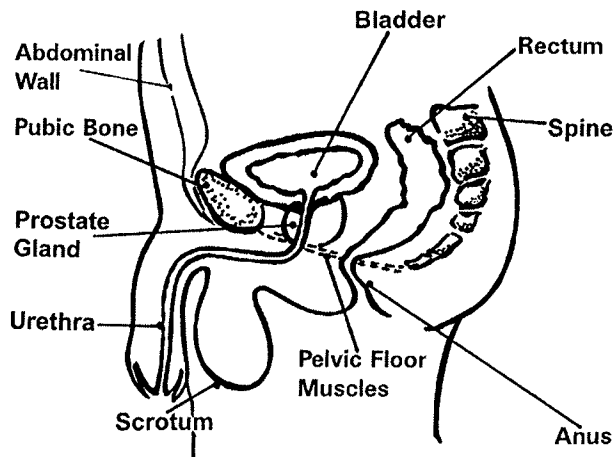
2. Drinking enough and the right kinds of fluids

Many people with bladder control issues decrease their intake of liquids in hope that they will need to urinate less frequently or have less urinary leakage. You should not restrict fluids to control your bladder. While a decrease in liquid intake does result in a decrease in the volume of urine, the smaller amount of urine may be more highly concentrated. Highly concentrated, dark yellow urine is irritating to the bladder surface and may actually cause you to go to the bathroom more frequently. It also encourages the growth of bacteria, which may lead to infections resulting in incontinence.

THE MALE PELVIC FLOOR MUSCLES

The pelvic floor consists of several layers of muscles that cover the bottom of the pelvic cavity. These muscles have several distinct roles:

1. To support the pelvic organs, the bladder and colon within the pelvis.
2. To assist in stopping and starting the flow of urine or the passage of gas or stool.
3. To aid in sexual appreciation.



HOW TO LOCATE THE PELVIC FLOOR MUSCLES

The Urine Stop Test

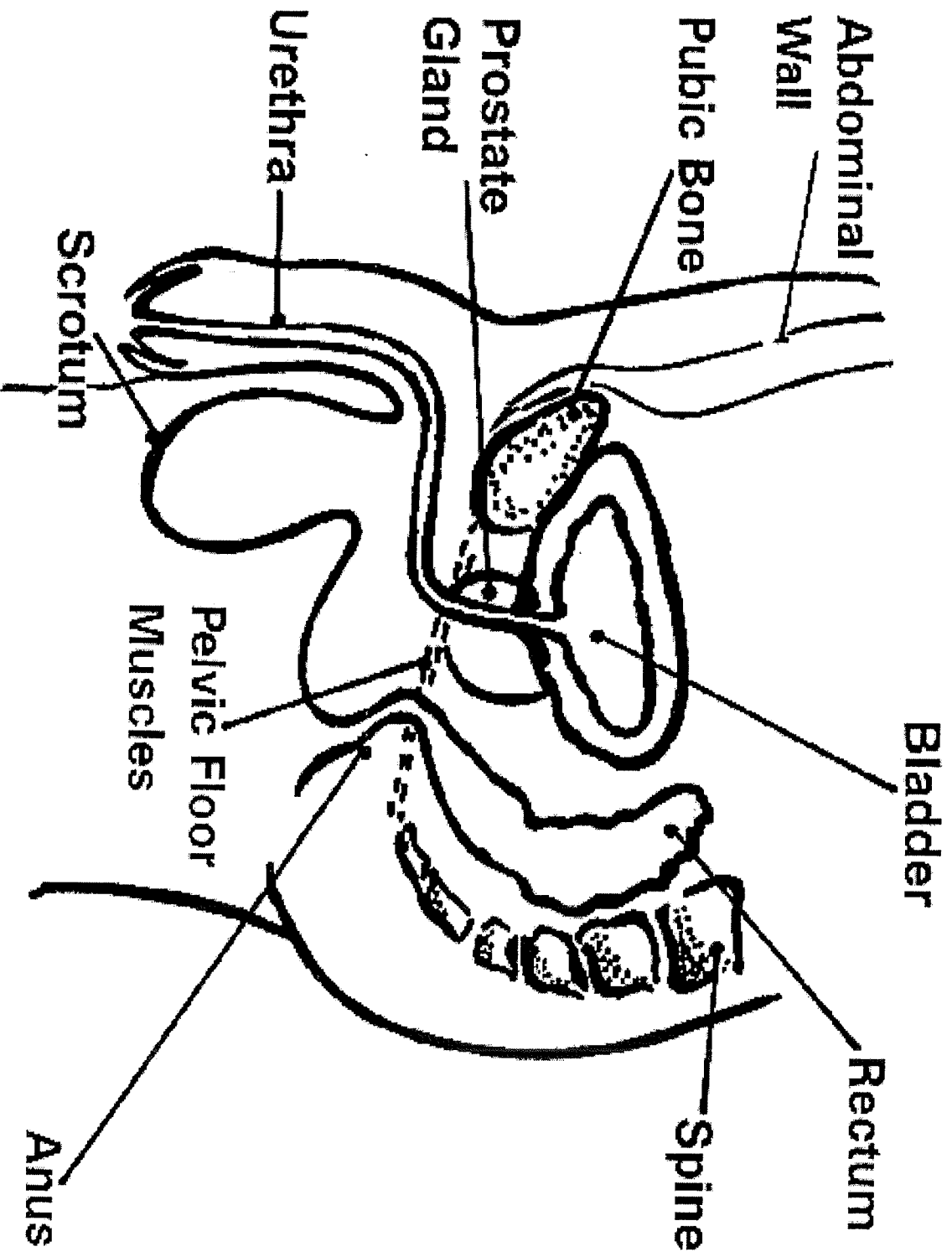
- At the midstream of your urine flow, squeeze the pelvic floor muscles. You should feel the sensation of the openings close and the muscles pulling up and in to the pelvic cavity. If you have strong muscles you will slow or stop the stream of urine.
- Try to stop or slow the flow of urine without tensing the muscles of your legs, buttocks.
- Do this only to locate the muscles, not as a daily exercise.

Feeling the Muscle

- Place a fingertip on or into the rectal opening. Contract and lift the muscles as though you were holding back gas or a bowel movement.
- You will feel your anal opening tighten and your penis move slightly.

Watching the Muscles Contract

- Begin by lying on a flat surface. Position yourself with your knees apart and bent with your head elevated and supported on several pillows. Use a mirror to look at the anal opening and penis.
- Contract or tighten the muscles around the anal opening and watch for a puckering and lifting of the anus and slight movement of the penis.
- If you see a bulge of your anus this is an incorrect contraction and you should notify your health care provider for more instructions.



KEEPING A RECORD OF BLADDER FUNCTION

The main purpose of a bladder log is to document how your bladder functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns. At first, the log is used as an evaluation tool. Later, it will be used to measure your progress on bladder retraining or leakage episodes. **Please complete a bladder log every day for 3 days and bring it with you to your appointment.**

Your log will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of the day exactly what happened in the morning.

INSTRUCTIONS

Column 1 - Time of Day

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold. Select the hour block that corresponds with the time of day you are recording information.

Column 2 - Type & Amount of Fluid & Food Intake

- Record the type and amount of **fluid** you drank
- Record the type and amount of **food** you ate
- Record when you woke up for the day and the hour you went to sleep

Column 3 - Amount Voided (Urinated): Three methods

Record the time of day and amount voided. Use the first method unless directed by your health care provider to directly measure or count urine amounts. Record a bowel movement with a BM at the appropriate time.

1. Place an S, M, L, in the box at the corresponding time interval each time you urinate.
S- SMALL= seemed like a small amount, or urinated "just in case".
M- MEDIUM= seemed like an 8 ounce measuring cup would run over.
L- LARGE= seemed like the amount you urinate when you first wake up in the morning.
2. If you have difficulty gauging the amount of urine, you may record seconds by counting "one - one thousand" (this equals one second) while emptying your bladder. Record the total number of seconds it took you to void.
3. Measure urine amounts with a collection device. The best method is a collection "hat" that can be placed directly over the toilet. Ask your provider where to get one. Some people use 2-4 cup measuring containers, but it is sometimes difficult to catch the urine with these. Record the measured ounces of urine in the box at the corresponding time interval each time you urinate.

Column 4 - Amount of Leakage

Record the amount of urine loss at the time it occurred.

- S- SMALL= drop or two of urine
- M- MEDIUM= wet underwear
- L- LARGE= wet outerwear or floor

Column 5 - Was Urge Present

Describe the urge sensation you had as:

- 1- MILD= first sensation of need to go
- 2- MODERATE= stronger sensation or need
- 3- STRONG= need to get to toilet, move aside!

Column 6 - Activity with Leakage

Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, bent over, lifted something or had a strong urge.

Comments – (at the bottom of the log table) Special problems and new or changes in medication are recorded here. If a pad change was needed, record the number used during the day at the bottom of the page.

Daily Voiding Log Sample

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided in Ounces or S /M /L or seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am	Woke up at 6:45 am	L		3	
7:00 am	Coffee, bagel				
8:00 am			M		Fast walking
9:00 am	Apple	M		2	
10:00 am					
11:00 am		S		1	Key in the door
NOON	Tuna sandwich, milk, pear				
1:00 pm					
2:00 pm		M		2	
3:00 pm	Tea, cookies		S		Running water
4:00 pm					
5:00 pm					
6:00 pm	Chicken, corn pudding, salad, apple juice	M		3	
7:00 pm					
8:00 pm			S	3	
9:00 pm					
10:00 pm	To bed at 10:30	M		3	
11:00 pm					

Comments: week before period Number of pads:

DAILY VOIDING LOG

Name _____

Date _____

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided Ounces, S /M /L or Seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
Noon					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments _____

Number of pads used today _____

DAILY VOIDING LOG

Name _____

Date _____

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided Ounces, S /M /L or Seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
Noon					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments _____

Number of pads used today _____

DAILY VOIDING LOG

Name _____

Date _____

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided Ounces, S /M /L or Seconds	Amount of Leakage S /M /L	Was Urge Present 1 /2 /3	Activity With Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
Noon					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments _____

Number of pads used today _____