METRO
SPINE & SPORTS
REHABILITATION

Name: _____ Date: _____

Physical Therapy Screening Questionnaire

Answering the following questions will help up to better manage your care. Please complete this questionnaire prior to your first appointment and give it directly to your therapist during your evaluation.
Do you now have or have you had a history of the following? Circle "Y" for Yes, N for No, and NA for not applicable.

Y/N Bone/ Join Problems
Y/N Low Back Pain
Y/N Abdominal Pain
Y/N Pelvic Pain
Y/N Painful Intercourse
Y/N Pain with Gynecologic exam

Y/N/NA Pain with Tampon Use
Y/N Bladder/ Kidney Infections
Y/N Bacterial Vaginosis
Y/N Frequent Yeast Infections
Y/N Painful Intercourse
Y/N Pain with Gynecologic exam

Y/N Menopause
Y/N Sexually Transmitted Disease
Y/N Multiple Sclerosis
Y/N Allergies
Y/N Smoking Habit
Y/N Other: _____

Please Explain any "Yes" responses listed above. Include dates: _____

_____

_____

How many glasses of fluid do you drink per day?____ How many are caffinated (Coffee, tea, soda)? ____

How often do you urinate each day? ____ Each night? ____ How often do you wet your bed each week? ____

Is the volume of urine you usually pass: Large Average Small Very Small

Do you hover over the toilet in public restrooms? Yes No Sometimes

Do you empty your bladder before you feel the need to urinate ("Just in case") so you stay dry? Yes No Sometimes

Is your clothing: Dry Damp (a few drops) Wet (underwear) Very Wet (outer clothes) Saturated (Floor)

For protection, do you use: Sanitary Pads Toilet Paper Diapers Nothing

Number used per day: _____

At each change, protective item is: Damp Wet Saturated

	Always	Sometimes	Never
Do you have trouble making it to the toilet in time?			
Do you find it hard to begin urinating?			
Do you have to strain to pass your urine?			
After you urinate, do you have dibbling or a full feeling?			
Do you have pain/ discomfort when you urinate?			
Do you lose urine when you have a strong urge to urinate?			
Do you lose urine with any of the following?			
Coughing or Sneezing			
Laughing			
Lifting			
Active exercise (running, etc.)			
Minimal exercise (walking, light housework)			
Sleeping			
Nervousness or increased anxiety			
Leakage unrelated to any specific cause			
Other (please explain below)			

_____

Name: _____ Date: _____

Do you have any bowel or gas control problems? Please explain. _____

_____

_____

Are you Pregnant? Yes No Maybe If yes, your due date: _____

Pregnancy #	Carried to term?	Vaginal (V) or Caesarian (C) delivery?	Date of delivery	Birth weight	Time spent pushing	Epistolatory or tear?
1	Y / N					
2	Y / N					
3	Y / N					
4	Y / N					
5	Y / N					
6	Y / N					

Pelvic floor dysfunction can be very distressing to patients. Whether your symptoms are urinary incontinence, fecal incontinence, constipation, pelvic floor pain or painful intercourse, these issues are not discussed openly with family, friends or even doctors.

In order to understand fully the scope of your individual diagnosis, there are some very important questions we need answered. Please feel free to be brief in your answers. If your therapists needs you to expand upon your answers, she will ask you privately.

1. Do your current sexual practices include sexual intercourse or activities that involve vaginal penetration? Yes No
   If "No", have they in the past? Yes No
2. Does your sexual practice (past or present) include anal entry activities? Yes No
3. Do you have any communicable diseases?
   If yes, please describe. _____ Yes No

_____

_____

4. Has there been any sexual abuse in your past? Yes No

_____ _____

Patient Signature Therapist Signature

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 Dysfunction may include, but is 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 and skin conditions, reflexes, muscle tone, length, strength and endurance, scar ability and function of the pelvic floor region. Such evaluation may involve vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but is not limited to, the following: observation, palpation, use of vaginal weight, 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 hereby acknowledge/understand the following:

1. My therapist has explained the purpose, risks, and benefits of this treatment to me.
2. I understand that I can terminate the treatment at any time.
3. I understand that I am responsible for immediately telling my therapist if I am having any discomfort or unusual symptoms during the evaluation.
4. I understand that I may request that a second staff member be present in the room during the treatment, given the sensitive nature of this procedure.
5. 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.
6. I agree to cooperate with and carry out the home program assigned to me, and if I have difficulty with any part of my treatment program, I will discuss it with my therapist.

_____ _____

Patient Name Date

_____ _____

Patient Signature Signature of Parent/Legal Guardian (if applicable)

_____

Staff Member/Witness Signature

PLEASE NOTE: if you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks postpartum or post surgery, have severe pelvic pain, sensitivity to lubricant gel/vaginal creams or latex, please inform the therapist prior to the pelvic floor assessment.