Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, **how much they bother you**. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptom scale:
0 = not present
1= not at all
2 = somewhat
3 = moderately
4 = quite a bit

Pelvic Organ prolapse Distress Inventory 6 (POPDI-6)

Do You...	NO	YES
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal distress Inventory 8 (CRAD-8)

Do You...	NO	YES
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary distress Inventory 6 (UDI-6)

Do You...	NO	YES
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

INFORMED CONSENT
for
ASSESSMENT AND TREATMENT OF THE PELVIC FLOOR

> Internal examination of the pelvic floor muscles is consistent with physical therapy practice. It complies with national physical therapy polices requiring the performance of test and measurements of neuromuscular function as an aid to the evaluation and treatment of a specific medical condition.
>
> -this statement was adopted by the executive committee of the Section on Obstetrics and Gynecology of the American Physical Therapy Association
>
> -San Antonio, Texas.... February 1993

I understand that it may be beneficial for therapist to perform soft tissue assessment and the treatment of the pelvic floor. Palpation of this area is most direct and accessible if done via vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain, urinary or fecal incontinence, dyspareunia (pain with intercourse), pain from episiotomy or scarring, vulvodynia, vestibulitis, or other conditions. Restrictions in this area may also be contributing to symptoms in other areas in the body.

I understand that the benefits of this procedure will be explained to me. I understand that, if I am uncomfortable with participating in this procedure AT ANY TIME, I will inform the therapist and the procedure will be discontinued and alternatives will be discussed with me.

This direct pelvic floor release procedure utilizes Myofascial Release principles entailing the relaxation and lengthening of muscles, fascia and other soft tissue structures within the areas of the pelvic floor, sacrum, coccyx, and the sacroiliac, hip and pubic joints. The procedure also requires pressure and/or distraction directly to the coccyx bone.

I have read and understand fully and consent to the above procedure being performed by the therapist at Neil King Physical Therapy clinic (141 Hampton Circle, Rochester Hills, MI 48307).

Patient's Name ______________________ Date ______________

Patient's Signature ______________________________________

Witness Signature ______________________________________

*** If you are pregnant, have infections of any kind, have vaginal dryness, are less than 6 weeks post partum or post surgery, have severe pelvic pain, using an IUD, sensitivity to KY jelly, vaginal creams or latex, **please inform the therapist prior to this procedure.**

MEDICAL HISTORY QUESTIONNAIRE - Male

Name: ______________________ **Primary care physician** ________________

Date of appointment ____________ **Referring Physician** __________________

Birth date ____________ **Next physician visit** ________

Describe the reason for your appointment (your main complaint/problem):

____

____

What goals do you hope to accomplish with therapy:

____

____

When did the problem begin? __________ **Is it getting better?** ☐ **Worse?** ☐ **Staying the same?** ☐

Have you ever been treated for this problem? ________ **If yes, how?**

____

List activities or things that you cannot do because of this problem. (How do your symptoms affect your life):

____

What are you doing to manage the problem currently:

____

PAST MEDICAL HISTORY: (Please mark if Yes)

	Childhood Illnesses		High Blood Pressure		Cancer
	Heart Problems		Chronic Cough		Emotional Problems
	Lung Disease		Diabetes		Psychiatric Disorder
	Kidney Disease		Bowel Problems		Arthritis
	Kidney Infections		Seizure Disorder/Epilepsy		Serious Injury, Accident
	Urinary Tract		Stroke		Glaucoma
	Liver Disease		Neurologic Disease		Thyroid Problems
	Back Problems		TB		Other

SURGICAL HISTORY: Have you ever had any operations? Yes ☐ No ☐ (If yes, please list)

Type of Surgery **Reason for Surgery** **Date of Surgery**

____

____

____

____

____

MEDICATIONS: Please list all of your present medications, including doses:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Do you have any allergies to medicines? Yes ☐ No ☐ Please list all medication allergies and reactions:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

SOCIAL HISTORY:

Current Marital Status: S ☐ M ☐ W ☐ D ☐
Are you sexually active? Yes ☐ No ☐
Occupation: ______________________________
Retired? Yes ☐ No ☐

Have you ever smoked tobacco? Yes ☐ No ☐
If so, how much? ______________________
Have you quit? Yes ☐ No ☐
Do you drink alcohol? Yes ☐ No ☐
If so, how much? ______________________
Do you use any street drugs? Yes ☐ No ☐
If so, what? ______________________

HEALTH HABITS: (Please answer in space provided)

Do you see a doctor regularly for exams? ______________________
How many hours do you sleep at night? ______________________
Do you eat a well-rounded diet? ______________________
Do you exercise regularly? ______________________
If yes, what type of exercise? ______________________
Do you consider yourself to be healthy? ______________________
Do you have any physical limitations? ______________________

Patient name: ______________________

Male Voiding Questionnaire	YES	NO
Have you been treated for more than two urinary tract infections this year?	☐	☐
When was the last time you had a urinary tract infection? ____________		
Is your urine ever bloody?	☐	☐
Have you ever been treated with urethral dilatation?	☐	☐
If so, how many times? ____________ Did it help?		
Childhood bladder habits		
Did you have difficulty holding urine as a child?	☐	☐
As a child did you wet the bed beyond age 5?	☐	☐
Urgency / Frequency		
Do you feel that you urinate too often?	☐	☐
Do you usually get up to urinate during the sleeping hours?	☐	☐
If yes, how many times? __________		
How many times during the day do you urinate?		
1-4 ☐ 5-8 ☐ 9-12 ☐ more than 12 ☐		
How often do you pass urine during the day? Every ________ hrs		
Is the volume of urine you usually pass?		
very small ☐ small ☐ average ☐ large ☐?		
Do you restrict your fluid intake because of your bladder problem?	☐	☐
Do you constantly feel an urge to urinate?	☐	☐
Do you often experience a strong, sudden urge to urinate?	☐	☐
Do you often feel you must rush to reach the toilet?	☐	☐
If yes, does it occur: all/most of the time ☐ half the time ☐ some of the time ☐		
How long can you hold back the urge to urinate? ______________		
Do you lose urine when you have the urge to urinate?	☐	☐
If yes, does it occur: all/most of the time ☐ half the time ☐ some of the time ☐		
Do you experience a strong sense of urgency with any of the following:		
Temperature changes	☐	☐
Running water	☐	☐
Entering the house	☐	☐
Approaching the toilet	☐	☐
Other: __________	☐	☐
Do you sometimes feel you need to urinate again immediately after urinating?	☐	☐
Do you void before leaving the house "just in case?"	☐	☐
Are you conscious of where the nearest toilet is when you are away from home?	☐	☐
Voiding symptoms		
Do you have difficulty emptying your bladder completely?	☐	☐
If yes, does it occur: all/most of the time ☐ half the time ☐ some of the time ☐		
How do manage this problem: ______________		
Is the urine stream ever hesitant or interrupted?	☐	☐
If yes, does it occur: all/most of the time ☐ half the time ☐ some of the time ☐		
Do you need to strain to empty?	☐	☐
If yes, does it occur: all/most of the time ☐ half the time ☐ some of the time ☐		
Do you have difficulty telling when your bladder is full?	☐	☐
Do you dribble just after urinating (i.e. when you stand up)?	☐	☐
If yes, does it occur: all/most of the time ☐ half the time ☐ some of the time ☐		
Do you have trouble stopping your urine midstream?	☐	☐

Urinary incontinence

	YES	NO
Do you experience uncontrollable loss of urine?	☐	☐
Do you lose urine with:		
Coughing	☐	☐
sneezing	☐	☐
lifting objects	☐	☐
straining	☐	☐
bending	☐	☐
walking	☐	☐
during intercourse	☐	☐
after intercourse	☐	☐

Is the volume you lose
☐ a few drops ☐ wet underwear or pad ☐ soaked pad or clothing

Do you lose urine with a strong urge that cannot be controlled?	☐	☐

If yes, does it occur:
all/most of the time ☐ . half the time ☐ some of the time ☐
Is the volume you lose
☐ a few drops ☐ wet underwear or pad ☐ soaked pad or clothing

In which positions does urine loss usually occur?

Lying down	☐	☐
Sitting	☐	☐
Standing	☐	☐
Moving from sitting to standing position	☐	☐

Is your loss of urine a continual drip so that you feel constantly wet?	☐	☐
Do you ever lose urine without any warning?	☐	☐
If yes, please explain when/how: ____________________		
Do you always feel when you lose urine?	☐	☐
Do you lose urine while you sleep?	☐	☐
Do you wear protection for urine loss?	☐	☐
What type? ____________ How many per day? ____________		
Do you experience hygiene or skin problems related to your leakage?	☐	☐

Bladder pain

Do you have discomfort associated with your bladder?	☐	☐

(if no, to above question, go directly to bowel section below)
If yes, location/description of pain ____________________

Indicate events that cause pain and rate the severity on a scale of 0 to 10 (0-none, 10 – the worst pain ever)

With bladder fullness	☐	pain rating ______/10
During voiding	☐	pain rating ______/10
After voiding	☐	pain rating ______/10
Other: ____________	☐	pain rating ______/10

What activities are limited by your pain?____________________
What makes pain worse? ____________________

Bowel habits	YES	NO
How often do you have a bowel movement? ____________________		
Do you ever attempt evacuation without results?	☐	☐
If yes, how often: ____________________		

Do you use any of the following to help you evacuate?
Laxatives (type ______________) ☐
Suppository ☐
Enema ☐
Manual removal ☐
Fiber supplement ☐
Other: ____________ ☐

Typical stool consistency:

Separate hard lumps, like nuts ☐
Sausage shaped but lumpy ☐
Like a sausage or snake but with cracks on surface ☐
Like a sausage or snake but smooth and soft ☐
Soft blobs with clear cut edges ☐
Fluffy pieces with ragged edges or mushy stool ☐
Watery, no solid pieces ☐
Combination of above ☐

	YES	NO
Do you ever experience blood in the stool or on the tissue?	☐	☐
Do you experience a sensation of the need to evacuate?	☐	☐
If yes, rate this sensation: normal ☐ blunted/uncertain ☐ strong/urgent ☐		
Do you constantly feel an urge to evacuate?	☐	☐
Do you lose stool with a strong urge that cannot be controlled?	☐	☐
If yes, does it occur: all/most of the time ☐ half the time ☐ some of the time ☐		
How long can you hold the urge to evacuate?____________		
Do you have a problem with constipation?	☐	☐
Do you strain to pass stool?	☐	☐
If yes, does it occur: all/most of the time ☐ half the time ☐some of the time ☐		
On average, how much time do you spend on the toilet for each evacuation? ________		
Do you have difficulty emptying your bowels completely?	☐	☐
-If yes, does it occur: all/most of the time ☐ half the time ☐ some of the time ☐		
-Do you feel stool remains: at the anal opening ☐ higher in the rectum/colon ☐		
Do you have difficulty with hygiene after a bowel movement?	☐	☐
Are you unable to feel the difference between solid or liquid stool and gas?	☐	☐

Are you unable to avoid passing gas in public? ☐ ☐
Do you experience uncontrollable loss of stool or stool seepage? ☐ ☐
(if you answered no to above question, go directly to bowel/abdominal pain section below)

Is the amount you lose
very small ☐ medium ☐ large ☐?

Do you lose stool with:

Cough/sneeze	☐	☐
Aerobic Exercise	☐	☐
Lifting/straining	☐	☐
Releasing gas	☐	☐
Urinating	☐	☐
Intercourse	☐	☐
No warning/urge	☐	☐

Is the amount you lose
☐ Stain/smear ☐ 2 Tbsp. or less ☐ ¼ to ½ cup ☐ ½ to 1 cup ☐ greater than 1 cup
If yes to above, consistency of stool loss: formed/solid ☐ hard balls ☐ loose/unformed ☐ liquid/mucous ☐
How often does this happen? ____________________

Do you lose stool with a strong urge that cannot be controlled? ☐ ☐
-does it occur: all/most of the time ☐ half the time ☐ some of the time ☐
Is the amount you lose
☐ Stain/smear ☐ 2 Tbsp. or less ☐ ¼ to ½ cup ☐ ½ to 1 cup ☐ greater than 1 cup
If yes to above, consistency of stool loss: formed/solid ☐ hard balls ☐ loose/unformed ☐ liquid/mucous ☐
How often does this happen? ____________________

Do you ever lose stool without any warning or urge? ☐ ☐
If yes, please explain when/how: ____________________
Do you loose stool without feeling it happen? ☐ ☐
If yes, please explain when and how ____________________

Does the stool loss, seepage or staining occur after bowel movement? ☐ ☐
Does the stool loss, seepage or staining during sleep? ☐ ☐

Do you wear protection for stool loss? ☐ ☐
What type? ____________ How many per day? ____________

Bowel / Abdominal pain
Do you experience pain related to bowel function? ☐ ☐
(if no, to above question, go directly to pelvic pain section below)
If yes, location/description of pain ____________________

Indicate events that cause pain and rate the severity on a scale of 0 to 10 (0-none, 10 – the worst pain ever)

Before bowel movement	☐	pain rating ______/10
During bowel movement	☐	pain rating ______/10
After bowel movement	☐	pain rating ______/10
With meals	☐	pain rating ______/10
Other: ____________	☐	pain rating ______/10

What activities are limited by your pain? ____________________
What makes pain worse? ____________________
What makes the pain better? ____________________
How long have you had the bowel pain indicated in the sections above? ____________
List any event that was associated with the onset of your bowel problem (such as an accident, surgery, childbirth) ____________________

Pelvic Pain

	YES	NO
Do you experience pelvic pain?	☐	☐

(if no, to above question, go directly to emotional factors section below)

If yes, give a description and location of the pain______________________________

Do you experience pain with intercourse?	☐	☐

Indicate events that cause pain and rate the severity on a scale of 0 to 10 (0-none, 10 – the worst pain ever)

Arousal	☐	pain rating _______/10
Thrusting	☐	pain rating _______/10
Orgasm	☐	pain rating _______/10

Does the pain continue after intercourse?

If yes, indicate: pain rating _______/10

How long does the pain last? ________ hours/days

Indicate other events that cause pain and rate the severity on a scale of 0 to 10 (0-none, 10 – the worst pain ever)

During rectal exam	☐	pain rating _______/10
Sitting	☐	pain rating _______/10
Certain clothing	☐	pain rating _______/10

Other (describe)______________________________ pain rating _______/10

What activities are limited by your pain?______________________________

What makes pain worse? ______________________________

What makes the pain better? ______________________________

How long have you had the pelvic pain indicated in the sections above? ______________________________

List any event that was associated with the onset of your pain symptoms (such as an accident, surgery)

____

Emotional factors

		YES	NO
Does emotional stress affect symptoms of your:	bladder	☐	☐
	bowel	☐	☐
	pelvic pain	☐	☐
Have you ever experienced	domestic violence	☐	☐
	rape	☐	☐
	sexual abuse / molestation	☐	☐
	incest	☐	☐
Have you ever been diagnosed with and/or treated for a nervous condition?		☐	☐
Have you ever been diagnosed with and/or treated for depression?		☐	☐

Symptom severity

Rate your feeling as to the current severity of your bowel, bladder, or pelvic floor problem on a scale of 1-10 with 10 being most severe.

0 1 2 3 4 5 6 7 8 9 10

Rate the following statement as it applies to you today, with 0 not true at all, 10 being true:

My problem is controlling my life.

0 1 2 3 4 5 6 7 8 9 10