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.

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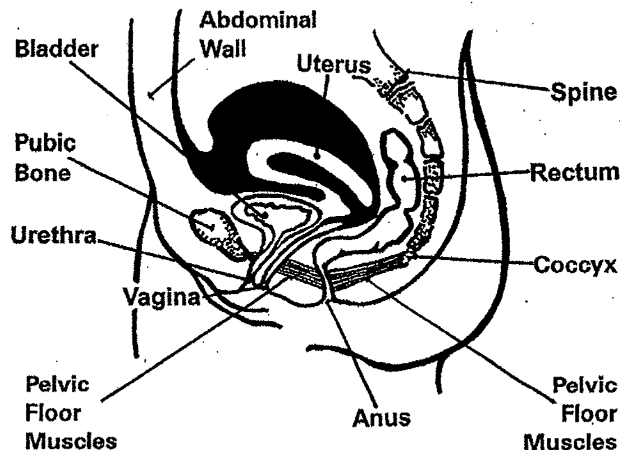
THE FEMALE PELVIC FLOOR

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, uterus 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 into 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

- You can insert 1 or 2 fingers into the vagina to feel the contraction and lifting of the muscles. You should feel the opening of the vagina tighten around your finger.
- Place a fingertip on the anal opening. Contract and lift the muscles as though you were holding back gas or a bowel movement. You will feel your anal opening tighten.

Watching the Muscle 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 and vaginal openings and the perineal body (the area between the two openings).
- Contract or tighten the muscles around the openings and watch for a lifting of the perineal body and closure of the openings.
- If you see a bulge or feel tissues coming out of your openings, this is an incorrect contraction and you should notify your health care provider for more instructions.

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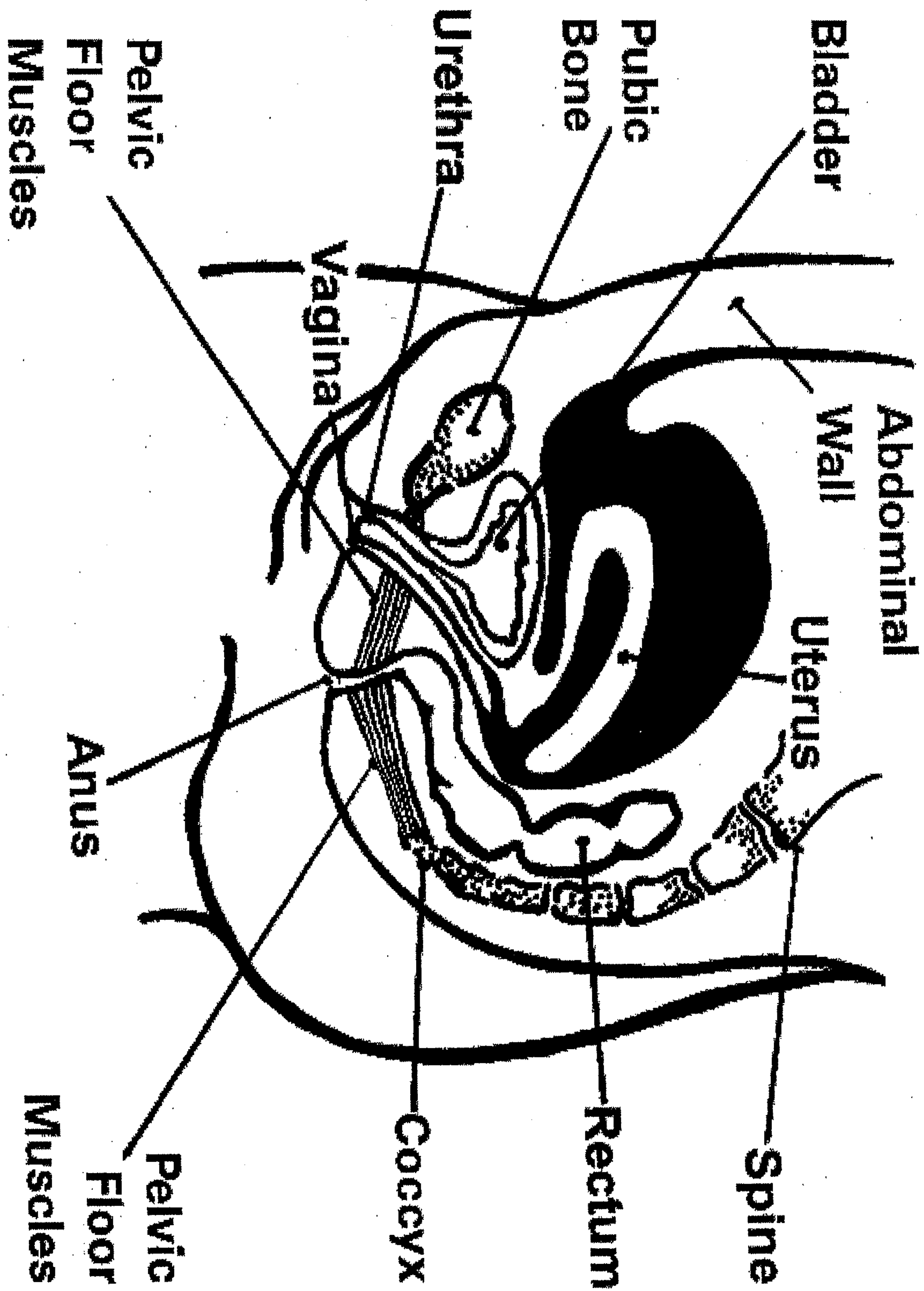

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HOW DIET CAN AFFECT YOUR BLADDER

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.

<u>Low acid fruits:</u> pears, apricots, papaya, watermelon

<u>For coffee drinkers:</u> KAVA®
Postum®
Pero®
Kaffree Roma®

<u>For tea drinkers:</u> 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.

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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 - 4 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

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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:___

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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 ______________

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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 ____________

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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 ______________

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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 ____________

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Patient: Date:

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed	❑ Oral

		❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:

Patient Signature: ______________________________ Date: ____________________

Reviewed by: ______________________________ Date: ____________________

CARE CONNECTIONS

PELVIC FLOOR WORKSHEET

NAME ______________________ DATE __________

TIME __________ AM/PM ☐ 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

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	☐	☐	☐	☐	☐	☐
2. Physical Activity/Exercise	☐	☐	☐	☐	☐	☐
3. Intimate Relationships	☐	☐	☐	☐	☐	☐
4. Sitting through long events (more than 3 hours)	☐	☐	☐	☐	☐	☐
5. Work Activities	☐	☐	☐	☐	☐	☐
6. Activities without bathroom access	☐	☐	☐	☐	☐	☐
7. Travel	☐	☐	☐	☐	☐	☐
8. Sleep (# times/night your sleep is interrupted)	☐0x	☐1x	☐2x	☐3x	☐4x	☐5+x
9. Number absorbent products used per day to manage your condition	☐0x	☐1x	☐2x	☐3x	☐4x	☐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

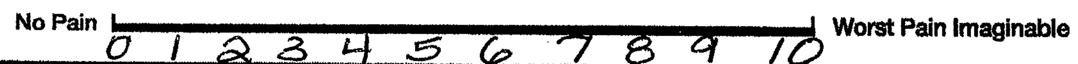
11. Number of bowel/urine leakage accidents per 24 hours? ______________

12. Frequency of daytime urination? ________

13. Frequency of nighttime urination? ________

PAIN INDEX

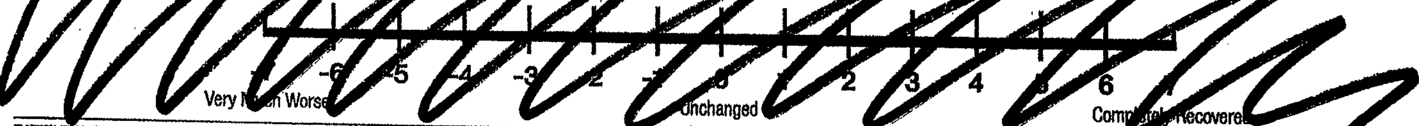
Please indicate the worst your pain has been in the last 24 hours on the scale below



PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)



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Physical Therapy Team Agreement

Welcome to Balanced Physical Therapy. We are glad that you have chosen to team up with us to help you meet your goals related to your injury or just improve your quality of life and function. We believe that together we can make this happen and that it requires extensive effort on both our parts. Only you can improve from where you are right now. We will help facilitate the process and help you through it by using our hands, equipment and educational tools.
Please read the following agreement and sign at the bottom to indicate you are a willing participant.

Scheduling: It is important that everyone arrive and be ready for the scheduled appointment time. **THERE IS A $50 CHARGE FOR MISSING A SCHEDULED APPOINTMENT OR FOR CANCELLING AN APPOINTMENT WITHIN LESS THAN 24 HOURS OF THE APPOINTMENT TIME.** We have a voicemail when we are not in the office. Appointments are scheduled for 45 minute sessions. It is important to have consistency with your appointments and keep them on a regular basis. Therefore, if 3 or more appointments are missed, this demonstrates lack of focus and responsibility and therapy may be placed on hold. We also prefer to have you work with one primary therapist and their assistant. From time to time we may ask one of our other therapists for their specialty advice to give you the best care.

Home Program: You will be given tools to use for self management and healing of your condition. This may include educational material to read, exercises or postures to use, equipment, or change in activity level. We will help you to set reasonable measurable goals. When either the goals are met or we determine that therapy is no longer assisting in your progress, you will be discharged from PT.

Communication: This is likely the most important component of this agreement. Help us help you by letting us know when you have a doctor's appointment, a change in your status, questions, or concerns. The best way for us to help you is by having access to concise, accurate information from you. We will share information with your doctor or referring healthcare provider as needed throughout your treatment. We also need you to follow the home program and any recommendations that are made. If you do not understand a component, then, please ask for clarification.

We want your time with us to be informative and helpful.

Thank you,

Debbie Lehner-Warner, PT
Jodi Decker, PT
Derek Fink, PT
Anna Potoczny-Jones, PT
Kahn Khabra, PT, DPT, OCS, MTC, FAAOMPT
Diane McKinley, LMT

______________________________ ______________________ Date______________
(Patient/Parent/Legal Guardian Signature) (Therapist signature)

Print Name: ____________________________

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 vagina and/or rectum. Pelvic floor dysfunctions' include pelvic pain syndromes, urinary incontinence, scarring, vulvodynia, vestibulitis or other similar complications. Evaluation of my condition may include observation, soft tissue mobilization, use of vaginal cones, vaginal or rectal sensors for biofeedback and/or electrical stimulation.

I understand that the benefits of the vaginal/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 vaginal 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

*** If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks post partum or post surgery, have severe pelvic pain, sensitivity to KY jell , vaginal creams, or latex, please inform the therapist prior to the pelvic floor assessment.*

Balanced Physical Therapy

Billing Policies

Updated: June 2016

As a courtesy to our patients, Balanced Physical Therapy will bill your insurance company if we are provided with all the necessary information. To avoid any confusion our policies are listed below.

IF YOU HAVE PRIVATE INSURANCE: _________ **initial**

(Example: Medicare, Blue Cross/Shield, UHC, Health Net, CUP....)

To ensure timely payments, you MUST identify the following information on the first visit:

A. Name of insured
B. ID number/group number and/or claim number
C. Insurance company billing address and telephone number
D. Provide Balanced Physical Therapy with a copy of your insurance card

If no payment is received from your insurance within 90 days, we will require payment from the patient to keep the account from going to collections (unless other arrangements are made).

AUTO ACCIDENT/THIRD PARTY CASES: _________ **initial**

We will bill auto insurance and other liability insurances if we are provided with the following information:

A. Name of insured
B. Claim number and Date of Accident
C. Insurance company billing address
D. Adjusters name and telephone number

If you are injured by someone else and don't have PIP coverage we will cooperate with you in processing your claim. We MAY agree to wait for payment of your bill from the proceeds of any settlement or judgment. However, you are still responsible for payment whether or not you collect from the insurance company. In cases where an attorney is involved, we require a Lien Agreement be signed to protect any balance for services provided. If your attorney refuses to sign the lien you must find other means of paying. Also, if your attorney refuses to sign the lien agreement and no payment has been made by any party within 90 days, we require a monthly payment to keep the account from going to collections (unless other arrangements are made).

ON THE JOB INJURIES: _________ **initial**

If you are injured on the job and you have an open claim we will bill the worker's compensation insurance and no payment by the patient is required. You must provide us with the following:

A. Worker's Compensation insurance company
B. Claim number and date of injury
C. Adjusters name and telephone number

If your claim is denied by worker's compensation we will bill your private health insurance-as long as you provide our office the pertinent information listed above. You are then responsible for any balance not covered.

CASH: _________ **initial**

As a courtesy to our patients who do not have health insurance coverage for whatever reason, we offer discounted rates when payment is received on the day services are provided.

PATIENT STATEMENTS: _________ **initial**

You will receive a patient statement **after** we receive an explanation of benefits from your health insurance. The services printed on the statement may not correspond with the amount that is due because we will only bill for dates of service listed on the most recent explanation of benefit. You will also receive an explanation of benefits from your insurance stating the amount you owe. If you are not insured, our staff will be glad to arrange an acceptable payment plan. No credit will be extended to patients having a delinquent account or who have been referred to a Collection Agency for payment. If this account is assigned to collections, you will be responsible for any collection cost, attorney fees and interest that may apply. Responsibility for payment of your account remains with you at all times; and although you may have an insurance claim pending, ultimately we must look to you for payment regardless of the circumstances involved. If your check is returned, there will be a $25 charge. All future payments will then need to be paid in cash. Please contact us if a problem arises.

- **LATE FEES:** _________ **initial.** Any balance due will be subject to a minimum $5 handling fee or 1% per month; from date of patient statement received.

INVENTORY ITEMS: _________ **initial**

You will be required to pay for inventory items and also orthotics on the day you receive them from our office. We will bill your insurance company if requested but you are ultimately responsible for any balance due, including tax, regardless if the insurance discounts the item.

_______________________________ Date _____________

Signature: Patient/Parent/Legal Guardian

Print Name: _______________________________