ST GEORGE
PHYSIOTHERAPY

PELVIC FLOOR SERVICE

We welcome you to St. George Physiotherapy Clinic. Our Pelvic Floor Physiotherapists have had extensive additional training to provide you with the care you will receive and are there to help you through your journey to improved care, function and quality of life.

We wanted to take a moment to explain to you and to go through with you what to expect on your initial visit to our clinic.

Upon booking your assessment with the front desk, we provide you with a link with forms that are for you to read, fill out and bring in for your first visit. These forms may take some time to fill out, therefore we have decided to have you fill them out with ample time from the comfort of your home. Do not worry if you are unsure about how to answer some of the questions – we ask that you mark the questions you are unsure of, and we can clarify them on your initial visit. You can also fill the forms out using the "fill and sign" function of Adobe Reader as the forms are in PDF format.

Your first visit will be approximately fourty-five minutes to an hour long with a Pelvic Floor Physiotherapist. During this time, you and your Physiotherapist will discuss the issue that brought you in for treatment. The Physiotherapist will ask you some more in-depth questions to gather more information about your condition.

Following the discussion of your condition, the Physiotherapist may wish to perform an external and/or an internal vaginal/rectal exam. Although the internal assessment is an important part of the overall assessment, we understand that not everybody is comfortable with it. The reasoning for the internal exam, is to measure directly the strength and condition of your pelvic floor musculature to provide a more informed treatment intervention. If you wish not to have an internal exam performed, you are free to withdraw consent to this portion of the exam. We can continue with other parts of the assessment to help us arrive at a personalized solution for you.

During the last part of your visit, the Physiotherapist will explain to you their findings, deliver some treatment and give you recommendations for you to follow at home until your next visit.

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Depending on your problem, the frequency of your follow up treatments will be once a week or every 2 weeks, which gives you the appropriate amount of time in between sessions in order for you to practice your self-care and your home exercise program.

We hope you find this information useful. Attached to this introductory page are questions related to your health history, a bladder diary and a consent form. Please fill out your health history as well as the consent form, if you are comfortable. If you need to discuss the consent form in more detail, please feel free to fill it and sign it when you see your Physiotherapist. Thank you for choosing us for the care of your Pelvic floor rehabilitation needs.

Should you have further questions please email us at info@stgeorgephysio.ca or call us at 416.921.4587.

Best Regards,

The Pelvic Floor Physiotherapy Team @St. George Physiotherapy Clinic.

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CONSENT FORM- PELVIC FLOOR REHABILITATION

PLEASE READ CAREFULLY

Pelvic floor physical therapy assessment and treatment may include, and is not limited to, the examination of the pelvic floor musculature via an *external and internal* examination, through the vaginal and Anorectal canals. This may occur during the initial assessment and may be required throughout subsequent treatments.

The goals of treatment include but are not limited to:

- improving urinary or fecal incontinence
- addressing bowel and/or bladder dysfunction (frequency/urgency)
- addressing sexual health
- reduction of pelvic/low back/sacroiliac joint pain
- improving strength and endurance of the pelvic floor musculature
- improving overall function and quality of life

Risks and/or side effects associated with an internal examination of the pelvic floor musculature may include:

- Discomfort (pain, cramping, burning) in the pelvic/perineal area during/post examination
- Urge to void (urinate or defecate) during examination
- Vaginal or rectal bleeding during or post examination
- Small risk of infection post examination
- Unexpected emotional response
- Skin reaction to gloves or lubricant
- Nausea and/or light-headedness

Treatment may include: Manual therapy of the pelvic floor, exercise therapy, biofeedback, electrical stimulation and education/advice regarding lifestyle. I give permission for my pelvic physiotherapist to perform an external and internal examination of my pelvic floor for rehabilitation purposes. I understand the risks and benefits associated with this treatment. I will immediately notify my therapist of any changes in my medical status. I will discuss with my therapist the nature and purpose of all treatments prior to their administration as well as benefits, risks, and alternatives. I understand that I may withdraw my consent at any time and discontinue treatment at any time.

Patient name: _____

Signature: _____

Date: _____

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Patient History – Pelvic Floor Rehabilitation

Name:_____ Date:_____

Date of Birth:_____

Occupation: _____

Hobbies/ sports:_____

Referred to physiotherapy by:_____

Referred to physiotherapy for: 1._____

2._____

When did this complaint start?_____

Treatment to date:_____

_____

Past medical history

Urinary tract/ yeast infections: No ( ) Yes ( ) How often?_____

Smoker: No ( ) Yes ( ) Per day?_____

Asthma/ respiratory condition: No ( ) Yes ( )

History of cancer No ( ) Yes ( ) Radiation ( ) Chemo ( )

Allergies:_____

Current weight:_____lbs Recent weight loss/ gain:_____

Height:_____

Previous surgeries:_____

Low back pain: No ( ) Yes ( )

Difficulty sleeping No ( ) Yes ( )

Other: _____

_____

Current meds: _____

_____

Drinks: Coffee_____cups per day Tea_____cups per day Water_____glasses per day

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Bowel History

Fecal incontinence: Yes ( ) No ( )

Constipation/ Straining: Yes ( ) No ( )

Stool consistency: Loose ( ) Soft/ formed ( ) Hard ( ) Varies ( )

Hemorrhoids Yes ( ) No ( )

Gynaecological History

Last menstrual period:_____ Pain worse during menses: Yes ( ) No ( )

Number of pregnancies:_____ Live births:_____ Ages of children:_____

Symptoms before pregnancy: Yes ( ) No ( )

Forceps Yes ( ) No ( ) Episiotomy Yes ( ) No ( )

Tears Yes (grade)_____ No ( ) Breach Yes ( ) No ( )

C-section Yes ( ) No ( )

Menopause onset:_____

Pelvic Pain

Pain during urination: Yes ( ) No ( )

Pain in genital area: Yes ( ) No ( )

Pain in lower abdomen: Yes ( ) No ( )

Pain during intercourse: Yes ( ) No ( ) When (women): at entrance ( ) deep ( )

Other info regarding pain:_____

Urinary Incontinence

Leaking occurs with: cough ( ) sneeze ( ) running ( ) walking ( ) lifting ( )

other:_____

Incontinence is preceded by a strong, uncontrollable need to urinate (urgency):

Never ( ) Sometimes ( ) Always ( )

Urinary frequency:_____times per day _____times per night

Episodes of incontinence:_____times per day _____times per night

Incontinence pads worn:_____per day

Need to strain when urinating: Yes ( ) No ( ) Sometimes ( )

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Urine flow: weak ( ) normal ( )

Bladder feels as though it does not empty completely Yes ( ) No ( )

PHYSIOTHERAPIST: _____

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NAME:
DATE:

Bladder Diary (PLEASE FILL OUT ONLY IF ASKED TO DO SO BY YOUR PHYSIOTHERAPIST)

This is a three-day bladder diary, which should be filled out over 3 consecutive days before your next physiotherapy appointment.

Please record all liquid intake and what the liquid was, e.g. 12oz coffee, 500ml water.

Include anything that is a liquid at room temperature, e.g. ice cream, soup.

You don't have to be very specific; a rough estimate of ounces or millilitres is fine.

When you go to the bathroom count how many seconds it takes to empty your bladder and write the number of seconds in the diary. Count slowly, e.g. ONE 1,000, TWO 1,000, THREE 1,000....
If your flow stops and starts, you can record this on your diary, e.g. 5/4/6.

If you needed to void more than once within one hour you should record all voids, e.g. 8, 4, 3.

Other information

In this column you can record any leak that occurred and why. Write an "S" for a leak that happened because of a stress activity and write down the activity, e.g. S (sneeze)

Write a "U" for any leak that happened because of urgency.

Also record in this column when you have a bowel movement (BM)

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Time	Liquid Intake	Urine Output (seconds)	Other Info
6am			
7am			
8am			
9am			
10am			
11am			
12am			
1pm			
2pm			
3pm			
4pm			
5pm			
6pm			
7pm			
8pm			
9pm			
10pm			
11pm			
12pm			
1am			
2am			
3am			

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4am			
5am			

Number of Incontinence Pads Used (if applicable) _____