ORTHOPEDIC PHYSICAL THERAPY, INC.

Male Pelvic Floor Intake Questionnaire

Date _____

Name _____ DOB _____

Primary MD _____ Referring MD _____

Insurance _____ Occupation _____

Reason for Referral _____

When did problem begin? _____

_____

_____

RELEVANT HISTORY

Medical History (Fill in background information on the following by checking all that apply to you)

High Blood Pressure_____
Heart Disease _____
Osteoporosis _____
Arthritis _____
Thyroid Condition _____
Respiratory Dysfunctions____
Recurrent muscle or joint pain _____

Diabetes _____
Breathing Problems _____
Cancer _____
Allergies _____(Please list)
Circulation Disease _____

Medicines Currently Taking: _____

_____

_____

Surgical History: _____

_____

_____

_____

_____

Personal History:

Regular Exercise _____
Dietary Habits (meat, fruit, veggies, fiber) _____
Caffeine Intake (coffee, tea, soda) _____
Fluid Intake/Day (water, juice, milk) _____
Sleep Habits (trouble falling asleep, staying asleep, reason for awakening, rested in AM, use of medications to sleep?) _____
Sexual Activity _____
Social _____ Limitations ? _____
Work _____ Sedentary _____ Travel _____ Active _____

Special Diagnostic Tests: (please check)

EMG ____
MRI ____
Cystoscope ____
Bladder Stress Test ___
Colonoscopy ____

Pudendal Nerve Test ____
Anal Ultrasound - Momonometry ____
Defecation Proctogram Study ____

Bowels (Loose/Normal/Constipated/Incontinent):_____

Form (small/hard, loose, soft/long) _____

Bowel Habits (frequency, any laxatives, etc.) _____

Do you strain to have a BM? _____

BM Frequency times/day _____ time/wk_____

Toileting Position _____Splinting Y/N _____%

Bowel Incontinence Symptoms: _____ N/A

Fecal Leakage _____ episodes per day___week___month ___ other _____

Leakage Amount _____Pads/day_____

Gas Control? Y/N ____ Other _____

BLADDER QUESTIONNAIRE Please answer these questions to the best of your ability.

	Never	Sometimes	Often
1) Do you leak urine when you cough, sneeze, laugh or when lifting?			
2) Do you ever have such an uncomfortable, strong need to urinate that if you don't reach the toilet you will leak?			
3) If "yes" to question #2, do you ever leak before you reach the toilet?			
4) Have you wet the bed in the past year?			
5) Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry?			
6) Do you have an urge to urinate when you hear running water?			
7) Do you have an urge to urinate when your hands are in water?			
8) Do you ever leak during or after sexual intercourse?			
9) Do you find it necessary to wear a pad because of leaking?			
10) If "yes" to questions #9, how many pads a day?			
11) Have you had bladder, urinary or kidney infections?			
12) Are you troubled by pain or discomfort when you urinate or BM?			
13) Have you had blood in your urine?			
14) Do you find it hard to begin to urinate?			
15) Do you have a slow urine stream?			
16) Do you strain to pass your urine or BM?			
17) After you urinate, do you have dribbling or a feeling that your bladder is still full?			
18) After BM, do you feel an incomplete emptying?			
19) Do you have burning when you void?			

PLEASE TRY TO GIVE ACTUAL NUMBERS	Number of times
20) How many times during the day do you urinate?	
21) How many times do you void during the night after you go to bed?	
22) How often do you leak?	
23) Leakage equals: Small (less that one-half cup) Large (more than one-half cup)	
24) How much warning time do you have to get to the toilet? Seconds or Minutes	

Pelvic Girdle Pain:

Are you sensitive to soaps, perfumes, deodorants or laundry detergents? Yes ____ No ____

Rate your pain on the 0-10 scale (10 being worse, ER visit necessary; 0-No pain):

Best _____ Average _____ Worst _____.

What activities make the pelvic pain worse? _____

What activities relieve the pelvic symptoms? _____

OBJECTIVE EVALUATION:

Observation: _____

_____

Orthopedic Exam:

AROM-Proximal Hips_____ MMT-Hips: L R
Knees_____ Knee: L R
Lumbar Spine_____ Ankles: L R

PROM (Hips): LEFT RIGHT
External Rotation
Internal Rotation
Straight Leg Raise
Abduction

Abdominal Strength:

Kendall curl-ups_____ leg lowering_____
Sahrmann/coordination (Bridges)_____
Diastasis: above_____ mid_____ below_____

SIJ Screen: Long Sit_____ ASIS Levels_____
Seated Flexion_____ PSIS Levels_____
FABER_____ ILA Sacrum_____
Provocation_____ Leg Length Left_____ Right _____

Palpation: Iliopsoas_____ Adductors_____
Gluteus Medius_____ Sacrotuberous Ligament_____
Piriformis____ Medial Hamstring____
Abdominals _____ Pubic Symphysis _____
Obturator Internus ___ Pubic Ramus _____
Ischial Tuberosity ___
Rectus Abdominus: Distal__ Proximal__ Umbilicus__
Inguinal ____ Transverse Abdominus ____
Greater Trochanters ___ Quadratus Lumborum ____

Pudendal Neural Tension:

Dorsal Branch ____ Perineal Branch ____
Inferior Rectal Branch ____ Posterior Femoral Cutaneous _____

PART II

Digital Exam: EAS Tone _____
- Pubococcygeal contraction MMT_____/5 (Laycock Scale) Symmetry ____
  Hold time_____ Reps_____
  Quick Reps_____
  Ability to Isolate_____
- Palpation for pain____ location _____Levator Ani ____
  Urotriangle _____

Pathway EMG Biofeedback: Sensors: internal/external
Peak Contraction_____microvolts
Max hold 5 seconds_____microvolts
Resting Tone PF_____ microvolts; abdominals _____ microvolts

Assessment: _____

_____

_____

_____

_____

Goals: 1) _____

2) _____

3) _____

4) _____

Rehab Potential: ☐ good ☐ fair ☐ poor

Obstacles to Rehab _____

Learning Barriers: ☐ absent ☐ present _____

Treatment Plan/Interventions: __times per week/month for__ months

☐ Patient/Client - related information/education:

- ☐ Pelvic floor anatomy & function
- ☐ Bladder & bowel health
- ☐ Dietary irritants
- ☐ Controlling urge
- ☐ Other _____
- ☐ Skin care
- ☐ Bladder/bowel retraining
- ☐ Constipation care
- ☐ Bladder/bowel log/diary

☐ Therapeutic exercise _____

☐ Kinetic activities _____

☐ ADL training _____

☐ Neuromuscular reeducation _____

☐ Manual therapy _____

☐ SEMG Biofeedback _____

☐ Electrical stimulation _____

☐ Home exercise program _____

_____

Duration: _____x/week for_____weeks._____Visits.

☐ Other _____

_____ Minutes of evaluation rendered _____ Minutes of treatment/ education rendered.

Signature: _____ Date _____