Informed consent for treatment:

The term “informed consent” means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction. Treatment may also include ____________________________________________

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist.

Potential benefit: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:
I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Cooperation with treatment:
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. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy
I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $ ____________

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of ____________________________________________

Date ____________  Patient Name: ____________________________________________

(Please Print)

Patient Signature __________________________________ Signature of Parent or Guardian (If applicable)

Witness Signature

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PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms

Your answers to the following questions will help us to manage your child’s care better. Please complete all pages prior to your child’s appointment.

Name of parent or guardian completing this form

Child’s name: _______________________________ Date: _______________________________

Age: ________ Grade: ________ Height: ________ Weight: ________

Describe the reason for your child’s appointment

When did this problem begin? ____________________ Is it getting better, worse, staying the same?

Name and date of child’s last doctor visit ____________________ Date of last urinalysis ____________________

Previous tests for the condition for which your child is coming to therapy. Please list tests and results ____________________

Medications

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<th>Start date</th>
<th>Reason for taking</th>
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Has your child stopped or been unable to do certain activities because of their condition? For example, embarrassed to play with friends, can’t go on sleepovers, feels ashamed about leakage and avoids play dates. ____________________

Does your child now have or had a history of the following? Explain all “yes” responses below.

Y/N Pelvic pain

Y/N Blood in urine

Y/N Low back pain

Y/N Kidney infections

Y/N Diabetes

Y/N Bladder infections

Y/N Latex sensitivity/allergy

Y/N Vesicoureteral reflux Grade ______

Y/N Allergies

Y/N Neurologic (brain, nerve) problems

Y/N Asthma

Y/N Physical or sexual abuse

Y/N Surgeries

Y/N Other (please list) ____________________

Explain yes responses and include dates ____________________

Does your child need to be catheterized? Y/N If yes, how often? ____________________

Bladder Habits

1. How often does your child urinate during the day? ________ times per day, every ________ hours.

2. How often does your child wake up to urinate after going to bed? ________ times

3. Does your child awaken wet in the morning? Y/N If yes, ________ days per week.

4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y/N

5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)

   ___ Not at all
   ___ 1-2 minutes
   ___ 3-10 minutes
   ___ 11-30 minutes
   ___ 31-60 minutes
   ___ Hours

6. Does your child take time to go to the toilet and empty their bladder? Y/N

7. Does your child have difficulty initiating the urine stream? Y/N

8. Does your child strain to pass urine? Y/N

9. Does your child have a slow, stop/start or hesitant urinary stream? Y/N

10. Is the volume of urine passed usually: Large Average Small Very small (circle one)

11. Does your child have the feeling their bladder is still full after urinating? Y/N
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? Y/N
13. Fluid intake (one glass is 8 oz or one cup)
   ___ of glasses per day (all types of fluid)
   ___ of caffeinated glasses per day
   Typical types of drinks
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e. running water, etc.) Y/N please list

   **Bowel Habits**

15. Frequency of movements: ___ per day ___ per week. Consistency: loose___ normal___ hard___
16. Does your child currently strain to go? Y/N__________ Ignore the urge to defecate? Y/N__________
17. Does your child have fecal staining on his/her underwear? Y/N How often?
18. Does your child have a history of constipation? Y/N__________ How long has it been a problem?

   **SYMPTOM QUESTIONNAIRE**

1. Bladder leakage (check all that apply)
   ___ Never
   ___ When playing
   ___ While watching TV or video games
   ___ With strong cough/sneeze/physical exercise
   ___ With a strong urge to go
   ___ Nighttime sleep wetting
2. Frequency of urinary leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day
   ___ Constant leakage
3. Severity of leakage (circle one)
   ___ No leakage
   ___ Few drops
   ___ Wets underwear
   ___ Wets outer clothing
4. Bowel leakage (check all that apply)
   ___ Never
   ___ When playing
   ___ While watching TV or video games
   ___ With strong cough/sneeze/physical exercise
   ___ With a strong urge to go
5. Frequency of bowel leakage-number (#) of episodes
   ___ # per month
   ___ # per week
   ___ # per day
6. Severity of leakage (circle one)
   ___ No leakage
   ___ Stool staining
   ___ Small amount in underwear
   ___ Complete emptying
7. Protection worn (circle all that apply)
   ___ None
   ___ Tissue paper / paper towel
   ___ Diaper
   ___ Pull-ups
8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10
   0_________________________________________________10
   Not a problem Major problem
9. Rate the following statement as it applies to your child's life today
   My child's bladder is controlling his/her life.
   0_________________________________________________10
   Not true at all Completely true