Your Physical Therapy appointment in the Women’s Health Department

What can I expect?
First, you will have a physical examination to identify pelvic floor and postural muscle dysfunction by:
• A screening of the low back and hip.
• An external and internal evaluation of the pelvic floor muscles.

Next: A treatment plan will be designed to reduce pain and restore function
Your personalized plan may include one or more of the following:
1. Treatment
2. Muscle re-education
3. Muscle stretching
4. Exercises
5. Posture and body mechanics training
6. Biofeedback evaluation and training
7. Relaxation training

How will I remember all this?
You will be given written instructions for your individualized home exercise plan.

How long is this appointment?
Evaluation and follow-up appointments are one-hour in length.

Should I come alone?
• You are welcome to bring an adult friend or family member with you to the appointment.
• We recommend children do not come to your appointment.

What is expected of you?
• Please complete the “Physical Therapy Questionnaire” given to you by your physician and bring it to your Physical Therapy appointment.
• You are expected to come to all scheduled appointments. Failure to do so may result in your being discharged from the program.

How do I get an appointment?
To book, cancel or reschedule, please call:
925-295-6173

We look forward to working with you,
Mary Russell, PT and Kathleen West, PT

What if I’m bleeding?
Menstruation is NOT a reason to cancel your appointment. Please come to this appointment even if you have started your period.
Women’s Health Physical Therapy Questionnaire

Name: _______________________________________
Kaiser Number: ____________________________
Age: ____________________________ Referring Provider: __________________________

Please complete and bring this questionnaire to your appointment. Thank you.

What is the problem you wish to talk to the physical therapist about today?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

1. On a scale of 1 to 10, what is your pain? ____________________________
   _____________________________________________________________________
2. How long have you had this problem? ____________________________ weeks/months/years
   If yes, when? _______________________________________________________
3. Have you been treated for this problem in the past? YES / NO
   If yes, when? _______________________________________________________
4. Are you currently taking medications for this problem? YES / NO
   If yes, what? _______________________________________________________
5. Are there activities you notice that aggravate this problem? YES / NO
   If yes, what? _______________________________________________________
6. Are there activities you notice that ease this problem? YES / NO
   If yes, what? _______________________________________________________
7. Do symptoms vary with your menstrual cycle? YES / NO
8. Are symptoms relieved by voiding your urine? YES / NO
9. Do you have pain with sexual activity? YES / NO
   If yes, since your first sexual experience or with your current partner? (Circle one)
10. Do you have a history of unpleasant or unwanted sexual experience? YES / NO
11. Do you have pain with a pelvic exam (pap smear)? YES / NO
12. Are you able to use a tampon? YES / NO / DO NOT USE

BLADDER HABITS
1. What is your daily fluid intake?
   □ Water: _________________
   □ Coffee/Tea: _________________
   □ Soda (Regular or Diet): _________________
   □ Alcohol: _________________
2. How often do you urinate every day? ____________________________
3. How often do you get up at night to urinate? ____________________________
4. Do you have urinary urgency? YES / NO
5. Do you have urinary leakage? YES / NO
6. Do you have pain when you urinate? YES / NO

BOWEL HABITS
1. Do you have leakage? YES / NO
2. Do you have difficulty defecating? YES / NO
3. Do you have constipation? YES / NO
4. Do you have diarrhea? YES / NO
5. Do you have pain with defecation? YES / NO
**OB/GYN History**

1. At what age did you start your menstrual cycle? ________________

2. Are your cycles regular? ................................................................. YES / NO

3. Do you usually have cramping or pain with your periods? ........................................... YES / NO

4. Is there any sexually transmitted disease (STD) history? ............................................. YES / NO

   If yes, please explain: ________________________________________________________________

5. How many pregnancies have you had? ________________

6. Out of those pregnancies, how many deliveries have you had? ____________

   □ How many were C-Sections? ____________
   □ How many were vaginal? ____________
   □ Were there any complications? ____________

7. Out of those pregnancies, how many abortions have you had? ________________

8. Out of those pregnancies, how many miscarriages have you had? ____________

9. How many tubal pregnancies have you had? ________________

10. How many living children do you have? ________________

**General Health**

1. Do you smoke? ........................................................................................................................................................................ YES / NO

   If yes, how many packs a day? ____________

2. What do you do for recreational activities/exercise? ___________________________________________________________________________________________________________________________

3. What is your occupation? ______________________________________________________________________________________________________________________________

4. What are 3 activities that you have difficulty with as a result of your problem?

   Score from 0 (unable to perform) to 10 (able to perform at pre-injury level)

   □ __________________________________________________________________________ SCORE: ____________

   □ __________________________________________________________________________ SCORE: ____________

   □ __________________________________________________________________________ SCORE: ____________

5. What are your goals for treatment?

________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

What can you expect during a Physical Therapy appointment?

- Appointments are 1 (one) hour long.
- An initial evaluation to identify pelvic floor and postural muscle dysfunction may include:
  - A musculoskeletal screening of the low back and hip range of motion and strength.
  - An external and internal evaluation of the pelvic floor muscles.
    ▪ This may be performed vaginally, rectally and/or with biofeedback.
- You will receive a treatment plan designed to reduce pain and restore function.
- You will be given written instructions for an individualized home exercise plan.
- **Menstruation is NOT a reason to cancel your appointment.** Please come to this appointment even if you have started your period.
- If you need to cancel or reschedule your appointment, please call: 925-295-6173
- **Please be careful when scheduling follow-up appointments as it is difficult to rebook in a timely manner and your treatment may be delayed.**

We look forward to working with you! Mary Russell, PT and Kathleen West, PT

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