



# HOOD RIVER PHYSICAL THERAPY

2690 May Street, Hood River, OR 97031 Phone 541-386-2441 Fax 541-386-5869

Dear Women's Health Patient,

We would like to take this opportunity to welcome you to the Women's Health Program at Hood River Physical Therapy. The purpose of this letter is to give you information regarding what to expect on your first clinic visit and also to give you a brief description of our Pelvic Muscle Rehabilitation Program.

There are two forms following this letter which we would appreciate your printing out and completing prior to your first physical therapy appointment. Please bring these completed forms with you to your first visit. It will help your therapist better understand your condition. These forms are entitled:

1. Women's Health Intake Form
2. Daily Bladder Habits Log

Your first visit to the clinic will take approximately 60 minutes. Please arrive 15 minutes early to complete any additional necessary paperwork.

Prior to your initial visit we are asking you to keep a diary of your bladder habits. This is an important component of your assessment, as it will give your Physical Therapist information that will be vital to accurately diagnosing, and prescribing the best program for you. Attached are two daily Diary Sheets; please fill these out for any two days before you attend your initial visit. If you are currently working, please ensure you have at least one workday, and one non-work day included in your diary. It is also important to be accurate, and to NOT change you normal habits, as it is your routine that will provide us with the most information.

To use the diary, please enter your name and date at the top; and then in the first column record every time you void in the first column. It is important that you count using the *steamboat* method for the duration of your void, each time during the day. (i.e. *one steamboat, two steamboats...*) In the second column note, what and how much you drink. In the third column, please record the time, and amount of leakage you have, and beside that, any activity that was related to the leakage. (i.e. lifting groceries). Finally, please note if you have episodes of urgency (feeling that you have to go now, and are unable, or almost unable to make it to the washroom).

During your initial clinic visit, your Physical Therapist will sit down with you to discuss the details of your condition, develop goals for the outcome of your treatments, and complete an examination. As part of the examination, we assess the strength and endurance of your pelvic muscles manually or using biofeedback,. This enables us to provide a program that will improve function to foster continence.

Follow-up visits will be scheduled at the end of your visit, and will be on a regular basis to measure and track your progress. This enables us to modify the program as needed.

Please feel free to invite someone to accompany you to your appointments if doing so would make you more comfortable.

Thank you very much for your help and cooperation. We look forward to working with you toward your goals.

If you have any questions please contact us at the clinic: (541) 386 2441.

Sincerely,

Laurie VanCott MSPT



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## **BIOFEEDBACK FOR THE PELVIC FLOOR MUSCLES**

### **WHAT IS BIOFEEDBACK?**

Biofeedback, also called Surface Electromyography (SEMG), is a learning technique that utilizes specialized equipment to assist a person in gaining control of their natural body functions. It involves the monitoring of a life process (bio) and the return of that information to the patient and therapist in a meaningful form (feedback).

Biofeedback training uses sensitive equipment that enables you to see or hear how your muscles are responding to your instructions. Becoming aware of these responses is the first step in learning to control them. By combining this information with special exercises, you can learn to relax tense muscles or strengthen weak muscles.

### **WHO USES BIOFEEDBACK?**

Your health care provider has recommended biofeedback evaluation and treatment for the muscles of your pelvic floor. These muscles are responsible for bladder and bowel control as well as sexual response. Anyone interested in learning how to relax tense muscles, strengthen weak ones, or to control and coordinate use of muscles may benefit from biofeedback.

### **WHAT DOES THE EVALUATION INVOLVE?**

For the evaluation you will use either an internal sensor, placed into the vagina or rectum, or external stick-on sensors placed around the rectal opening. These sensors are used to monitor the muscle activity of your pelvic floor. This enables you and your therapist to see and evaluate resting muscle activity as well as evaluate your muscle strength and endurance. The results of your evaluation will help your therapist design a specific treatment plan for your needs.

### **WHAT IS REQUIRED AFTER THE EVALUATION?**

Your exercise program will depend upon the results of your evaluation. Almost everyone is asked to carry out a home exercise program utilizing the skills and exercises they learn in the clinic. Some people need special home biofeedback equipment to help them monitor their exercise program. If this is necessary for you, the equipment can be either rented or purchased. Your therapist will guide your treatment program, which usually takes 2 - 8 visits to the clinic.

Please feel free to ask us for more information on biofeedback and its uses.



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## Women's Health Intake Questionnaire Urinary Incontinence\*

Name \_\_\_\_\_

Age \_\_\_\_\_

Sex: F / M

Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Do you have uncontrolled loss of urine?

Yes No

How long have you had this problem?

\_\_\_\_\_

How often do you leak urine?

\_\_\_\_\_

Do you have bowel changes?

Yes No

If yes, do you have:

Diaherria

Constipation

Both

Have you changed activities as a result of your problem?

Yes No

Do you leak when you cough, sneeze, lift, run, or jump?

Yes No

Do you have sudden urgency and leak before you can get to the toilet?

Yes No

If so, how long can you hold your urine once your bladder is full?

\_\_\_\_\_

Do you have either a strong or a weak urine stream?

Neither

Strong

Weak

Can you stop and start urine flow easily?

Yes No

How many times do you get up during the night to urinate?

\_\_\_\_\_

How many times a day do you urinate?

\_\_\_\_\_

How much do you drink a day?

\_\_\_\_\_

What types of beverages do you normally drink?

\_\_\_\_\_

Have you changed your fluid consumption?

Yes No

Do you have pain during urination?

Yes No

Do you have pain during intercourse?

Yes No

Do you have frequent bladder infections?

Yes No

Have you ever been pregnant?	Yes	No
If so, how many times?	_____	
Have you had any C-sections?	Yes	No
Have you had any complications with pregnancy?	Yes	No
In the case of vaginal delivery, how long did you push?	_____	
Did you have an episiotomy?	Yes	No
Did you have any trouble with leakage during pregnancy?	Yes	No
Have you had any toileting pattern changes with menopause?	Yes	No
Is your urine loss enough that you use protection?	Yes	No
If yes, what do you use?	_____	
How many times a day do you have to change your protection?	_____	
What type of pad do you use?	_____	

Please provide a list of all current medications, prescription and over the counter.

	Name	Dose	Used for what	Start Date
i.e.	Tylenol	500 mg	Pain	Feb 5 2003
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Please provide a list of any surgeries you have had, and include the date.

	Surgery	For What	Date
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please list any other types of treatments / tests which you have had, or are planning to have for your urine control problem.

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Is there anything else you would like to comment on or add to the information on this form? \_\_\_\_\_

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## *Daily Bladder Habits Log*

*Name:* \_\_\_\_\_

*Date:* \_\_\_\_\_

*Instructions:* Use this diary to keep record of your routine. Use one per day.

- Record when you void and the amount (use the counting method -i.e. steamboats)
- Record fluid intake (when, what type and how much)
- Record any leaking, any activity associated with the leakage, and if there was urgency related to the leakage.
- Record if you are using a pad, and when you change your pad.

<b><u>Time</u></b>	<b><u>Voiding</u></b>	<b><u>Fluid IN</u></b>	<b><u>Leaking</u></b>	<b><u>Activity</u></b>	<b><u>Urgency??</u></b>
6 am					
7 am					
8 am					
9 am					
10 am					
11 am					
12 pm					
1 pm					
2 pm					
3 pm					
4 pm					
5 pm					
6 pm					
7 pm					
8 pm					
9 pm					
10 pm – 12 am					
12 – 3 am					

*Number of Pads used:* \_\_\_\_\_ *Comments:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_