Anniken Chadwick
PHYSIOTHERAPY FOR PELVIC HEALTH

Pelvic Floor Physiotherapy Assessment

Date:

Name: Age: Occupation:

Family MD: Specialist: Note:

Diagnosis: _____

Presenting Symptoms:

_____

_____

_____

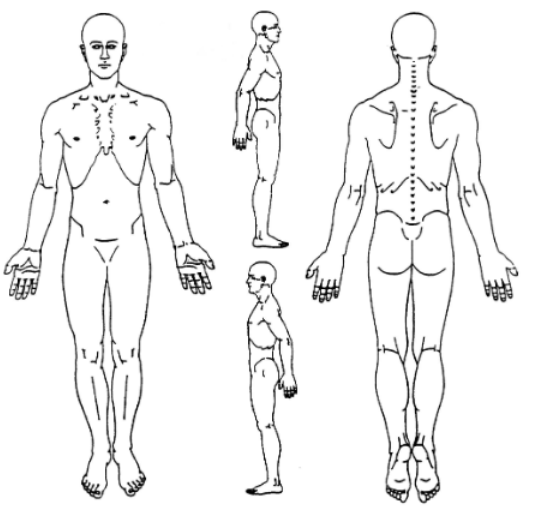
PAIN:

Aggs

Eases

VAS

24 hr



OBSERVATION:

Posture

Breath pattern

DRA

Pelvis

Hips

Abdo

Exam:

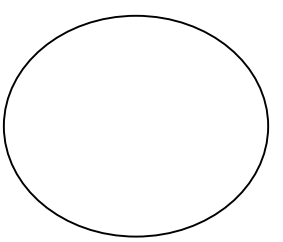
Genital hiatus length (N=3cm)

Introitus

Contract

Bear down

Cough



Pelvic Floor Physiotherapy Assessment

PROLAPSE:

	Resting	Bear down
AVWP		
PVWP		
Total vaginal Length		
Rectal prolapse		

PELVIC FLOOR MUSCLE

Performance		Co-contraction of TA	
Endurance		Timing	
Repetitions		Symmetry	
Fast		Accessory mm use	
Elevation			

Tone:

Awareness:

Breath:

ANORECTAL ASSESSMENT:

Observation (skin, scars, hemorrhoids, fissure):

EAS (cough)

IAS

Puborectalis tone

Bear down

Anorectal angle

Coccyx

Coccygeus

Post vag wall

TREATMENT:

Anniken Chadwick
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Pelvic Floor Therapy Questionnaire

PATIENT NAME: _____ DATE: _____

Please fill in the following questionnaire to the best of your ability.

Date of last pelvic exam/pap: **Date of last urinalysis:**

Have you had any previous treatment for incontinence? YES NO
Please explain:

_____

_____

_____

MEDICATIONS (please list all medications you are presently taking including vitamins and supplements):

_____

_____

_____

SURGERIES: _____

_____

OBSTETRICAL HISTORY:

Number of pregnancies _____ Number of vaginal deliveries _____

Birth weight of largest baby _____ Number of caesarean deliveries _____

Year of children(s) birth(s) _____

Circle if yes: forceps breech tears episiotomy

EXERCISE:

Do you get any regular exercise? YES NO

If yes, what do you do? _____

Are stress or anxiety affecting your life?

Anniken Chadwick
PHYSIOTHERAPY FOR PELVIC HEALTH

Pelvic Floor Therapy Questionnaire

Please circle Y= yes or N= no for history of any of the following:

Y N Did you have any trouble healing after delivery

Y N Osteoporosis

Y N Bladder infections

Y N Pelvic/abdominal pain

Y N Low back pain

Y N Sexually transmitted disease

Y N Menopause

Y N Are you having regular periods/ menstrual cycles

Y N Sexual abuse or trauma

Y N Physical abuse

Y N Irritable bowel syndrome

Y N Constipation

Y N Cancer

Y N Diabetes

Y N Neurological problems such as: Stroke, Parkinson's, Multiple Sclerosis, Head injury

Y N Blood in stool

Y N Blood in urine

Y N Significant injury

Please explain the above responses and add any more information not yet asked:

_____

_____

_____

GOALS FOR TREATMENT (your expectations):

_____

_____

_____

RATE YOUR PROBLEM

0 5 10

0 means no problem & 10 means it really interferes with your life or bothers you a lot.