PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

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

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:_____Prefers to be called _____ 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	Start date	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 Low back pain
Y/N Diabetes
Y/N Latex sensitivity/allergy
Y/N Allergies
Y/N Asthma
Y/N Surgeries
Y/N Blood in urine
Y/N Kidney infections
Y/N Bladder infections
Y/N Vesicoureteral reflux Grade ____
Y/N Neurologic (brain, nerve) problems
Y/N Physical or sexual abuse
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

YOUR BLADDER LOG INSTRUCTIONS

Why keep your log?

The main purpose of a bladder log is to keep track of how your bladder functions. A log can give your health care provider an excellent picture of your bladder function, habits and patterns. In the beginning, the log is used as an evaluation tool. Later, it will be used to measure progress. Please complete a bladder log every day for _____ days and bring it with you to your next appointment.

The log plays an important part in your health care provider's ability to understand the problem and provide you with the appropriate, specialized treatment plan. The log will be much more accurate if it is filled it out throughout the day. It can be very difficult to remember at the end of the day exactly what happened in the morning. Do the best that you can if your child is in school during the day. Perhaps enlist the help of a teacher or aide.

Instructions

Column 1 - Type and Amount of Fluid and Food Intake:
Record;

1. The types and amount of fluid drank, (1 cup or ½ cup is OK)
2. The types of food eaten
3. Bedtime and when awakening time, including naps

Column 2 - Amount Voided (Urinated): Two methods
Use method 1 unless directed by your health care provider to measure urine in exact amounts.

1. Measuring urine in seconds - To measure in seconds begin counting as soon as the urine comes out and stop counting when the urine stops coming out. If one or two more drops come out after that do not count these. If you have difficulty gauging the amount of urine, you may record seconds by counting "one one thousand" while emptying your bladder. Record the number of seconds voided.

2. Measuring urine exactly - Occasionally your health care provider may need to know **exactly** how much urine comes out. To measure exact urine amounts obtain a collection device. The best one is a collection "hat" that can be placed directly over the toilet. Ask your provider where to get one. Some people use 2-4 cup measuring containers, but it is sometimes difficult to catch the urine with these. Record the measured amount of urine in the box at the corresponding time interval each time you urinate.

Column 3 - Amount of Leakage:
SMALL= drop or two of urine
MEDIUM= wet underwear
LARGE= wet outerwear or floor

Column 4 - Activity with Leakage & Was Urge Present:
Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, playing with friends or had a strong urge.
Describe the urge sensation you had to go as:
MILD= first sensation of need to go.
MODERATE =stronger sensation or need.
STRONG =need to get to toilet, move aside!

Comments – Special problems. If underwear or clothing change was needed, record at the bottom of the page.

Daily Bladder Log (Sample)

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided in ounces, cc or seconds	Amount of Leakage SM/MD/LG	Activity With Leakage & Was Urge Present
12:00a				
1:00				
2:00				
3:00				
4:00				
5:00				
6:00	Woke up 6:30		LG	Woke up wet
7:00	½ cup Chocolate milk, bagel	19 sec.		
8:00			SM	Recess. Mod. urge
9:00	Apple			
10:00				
11:00				
12:00p	Tuna sandwich, 1 cup milk, pear	16 sec.		
1:00				
2:00			SM	Didn't stop playing
3:00	½ cup Milk, cookies	11 sec.		
4:00				
5:00				
6:00	Chicken, corn pudding, carrots, salad. Apple juice (box-6 oz)	9 sec.		
7:00				
8:00	Went to bed			
9:00				
10:00				
11:00				

Comments: changed underpants 2 times

DAILY BLADDER LOG

Name: _____ Date: _____

Time of Day	Type and Amount of Food and Fluid Intake	Amount Voided in ounces, cc or seconds	Amount of Leakage SM/MD/LG	Activity With Leakage & Was Urge Present
12:00a				
1:00				
2:00				
3:00				
4:00				
5:00				
6:00				
7:00				
8:00				
9:00				
10:00				
11:00				
12:00p				
1:00				
2:00				
3:00				
4:00				
5:00				
6:00				
7:00				
8:00				
9:00				
10:00				
11:00				

Comments: _____