



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

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and three scales of your symptoms. All these items use the following format with a response scale from 0 to 4.

Symptom scale: 0 = not present (0%)  
 1 = not at all ( $\leq 25\%$ )  
 2 = somewhat ( $\leq 50\%$ )  
 3 = moderately ( $\leq 75\%$ )  
 4 = quite a bit ( $\geq 75\%$ )

### Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you...	NO	YES
Usually experience pressure in the lower abdomen?	0	1 2 3 4
Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

### Colorectal-Anal Distress Inventory 8 (CRAD-8)

Do you...	NO	YES
Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
Usually loose stool beyond your control if your stool is loose?	0	1 2 3 4
Usually lose gas from the rectum beyond your control?	0	1 2 3 4
Usually have pain when you pass your stool?	0	1 2 3 4
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4



Urinary Distress Inventory 6 (UDI-6)

Do you...	NO	YES			
Usually experience frequent urination?	0	1	2	3	4
Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1	2	3	4
Usually experience urine leakage related to coughing, sneezing or laughing?	0	1	2	3	4
Usually experience small amounts of urine leakage (that is, drops)?	0	1	2	3	4
Usually experienced difficulty emptying your bladder?	0	1	2	3	4
Usually experience pain or discomfort in the lower abdomen or genital region?	0	1	2	3	4

# The Pelvic Girdle Questionnaire

## Appendix 1: Pelvic Girdle Questionnaire (English Version)<sup>a</sup>

To what extent do you find it problematic to carry out the activities listed below because of pelvic girdle pain? For each activity tick the box that best describes how you are today.

How problematic is it for you because of your pelvic girdle pain to:	Not at all (0)	To a small extent (1)	To some extent (2)	To a large extent (3)
1. Dress yourself				
2. Stand for less than 10 minutes				
3. Stand for more than 60 minutes				
4. Bend down				
5. Sit for less than 10 minutes				
6. Sit for more than 60 minutes				
7. Walk for less than 10 minutes				
8. Walk for more than 60 minutes				
9. Climb stairs				
10. Do housework				
11. Carry light objects				
12. Carry heavy objects				
13. Get up/sit down				
14. Push a shopping cart				
15. Run				
16. Carry out sporting activities*				<input type="checkbox"/>
17. Lie down				
18. Roll over in bed				
19. Have a normal sex life*				<input type="checkbox"/>
20. Push something with one foot				

\*If not applicable, mark box to the right.

How much pain do you experience:	None (0)	Some (1)	Moderate (2)	Considerable (3)
21. In the morning				
22. In the evening				

To what extent because of pelvic girdle pain:	Not at all (0)	To a small extent (1)	To some extent (2)	To a large extent (3)
23. Has your leg/have your legs given way?				
24. Do you do things more slowly?				
25. Is your sleep interrupted?				

<sup>a</sup>Scoring procedure: the scores were summarized and recalculated to percentage scores from 0 (no problem at all) to 100 (to a large extent).



## CONSENT FOR EVALUATION AND TREATMENT OF PELVIC FLOOR DYSFUNCTION

I acknowledge and understand that I have been referred to **NORMAN PHYSICAL THERAPY** for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to: urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, and vulvar or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. I understand that this evaluation and/or treatment could potentially elicit pain or discomfort.

Treatment may include, but not limited to the following: observation, palpation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

I understand that no guarantees have been or can be provided regarding the success of therapy. I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the physical therapist, physical therapist assistant, and technician.

Patient Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Signature of parent/guardian (if patient is a minor): \_\_\_\_\_

Witness signature: \_\_\_\_\_