KIDZ KORNER

The Pediatric Therapy SPOT

PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that my child has been referred to Kidz Korner for evaluation and treatment of pelvic floor dysfunction.

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 child's condition. I understand that to evaluate my child's condition it may be necessary, initially and periodically, to have the therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external pelvic floor region. This evaluation will assess skin condition, reflexes, muscle, tone, length, strength and endurance, and function of the pelvic floor region. The parent or legal guardian may be present at the time of the pelvic floor examination.

Treatment may include but is not limited to the following: observation, palpation, biofeedback, electrical stimulation, stretching, strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: Your child may experience a slight increase in current level of pain or discomfort if any, or a slight aggravation of an existing injury. This discomfort is usually temporary.

I hereby request and consent to the evaluation and treatment to be provided by the therapists of Kidz Korner.

Date: ____________ Patient name: ___________________________
(Please print)

________________________________ ________________________________
Patient signature Signature of Parent or Guardian

Pelvic Health Questionnaire:

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? ☐ Yes ☐ No If yes, ______ days per week.
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? ☐ Yes ☐ No
5. How long does your child delay going to the toilet once he/she needs to urinate? ________________
6. Does your child take time to go to the toilet and empty their bladder? ☐ Yes ☐ No
7. Does your child have difficulty initiating a urine stream? ☐ Yes ☐ No
8. Does your child strain to pass urine? ☐ Yes ☐ No
9. Does your child have a slow, stop/start, or hesitant urinary stream? ☐ Yes ☐ No
10. Is the volume of urine passed usually: *(circle one)* Large Average Small Very Small
11. Does your child have the feeling their bladder is still full after urinating? ☐ Yes ☐ No
12. Does your child have any dribbling after urination; i.e. once they stand from the toilet? ☐ Yes ☐ No
13. Fluid intake (one glass is 8oz or 1 cup):
    a. Typical types of drinks drinks:_______________________________
    b. ______ glasses per day (all types of fluid) ______ caffeinated glasses per day
14. Does your child have "triggers" that make him/her feel like they can't wait to go to the toilet? (i.e. running water, etc) ☐ Yes ☐ No; Please list: _______________________________________

Bowel Habits:

1. Frequency of bowel movements: ______ per day; ______ per week
    a. Consistency:☐ Loose ☐ Normal ☐ Hard

2. Does your child currently strain to go? ☐ Yes ☐ No

3. Does your child ignore the urge to defecate? ☐ Yes ☐ No

4. Does your child have fecal staining on his/her underwear? ☐ Yes ☐ No How often? ___________

5. Does your child have a history of constipation? ☐ Yes ☐ No
   a. How long has it been a problem? _______________

Bladder leakage: (check all that apply)	**Bowel leakage:** (check all that apply)
Occurrence: ___ Never ___ When playing ___While watching TV or video games ___With a strong cough/sneeze/physical exercise ___ With a strong urge to go ___ Nighttime sleep wetting	Occurrence: ___ Never ___ When playing ___While watching TV or video games ___With a strong cough/sneeze/physical exercise ___ With a strong urge to go
Frequency: ___ # per month ___ # per week ___ # per day ___ constant leakage	Frequency: ___ # per month ___ # per week ___ # per day
Severity: ___ No leakage ___ Few drops ___ Wets underwear ___ Wets outer clothing	Severity: ___ No leakage ___ Stool staining ___ Small amount in underwear ___ Complete emptying
Protection worn for bladder leakage: ___ None ___Tissue paper/toilet paper ___ Diaper ___ Pull-ups ___ Panty liners	Protection worn for bladder leakage: ___ None ___Tissue paper/toilet paper ___ Diaper ___ Pull-ups

Ask your child to rate his/her feelings as to the severity of the problem from 0-10: ________________________

(0 is no problem at all; 10 is a major problem)

Rate the following statement as it applies to your child's life today from 0-10: "My child's bladder/bowel is controlling his/her life" ____________________________

(0 is no problem at all; 10 is a major problem)

EXAMPLE

Bowel and Bladder Diary

Please complete for 3 days. See example for details.

Day/Date: ________________

	FOOD	DRINK	PEE	POOP
	What you ate today	Glasses or ounces of liquid consumed	Please count how long you pee (i.e. 8 seconds)	Please use the Bristol Poop Scale (i.e. #2 poop)
Midnight to wake-up			Wet pull-up	
Breakfast	Cherrios with milk Orange	3oz apple juice	10 seconds	
Between breakfast and lunch	1 graham cracker			Poop #1
Lunch	Peanut butter and jelly sandwich on wheat bread ½ banana	6oz water		
Between lunch and dinner			7 seconds	
Dinner	½ cup of rice noodles with tomato sauce ¼ cup of mixed veggies	8oz water		

Between Dinner and Bedtime			9 seconds	
Bedtime to Midnight				

Please indicate if this is a school or non-school day: _______________________

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Breakfast				
Between breakfast and lunch				
Lunch				
Between lunch and dinner				
Dinner				

Between Dinner and Bedtime				
Bedtime to Midnight				

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