

Hypopressives Brisbane



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Please do NOT do the Hypopressive Vacuum Hold if you are Pregnant, have High Blood Pressure or have a hiatus hernia.

Questionnaire - Pelvic Floor

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 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptom scale:

- 0 = not present
- 1 = not at all
- 2 = somewhat
- 3 = moderately
- 4 = quite a bit

Pelvic Organ prolapse Distress Inventory 6 (POPDI-6)

Do You...	NO	YES
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. 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
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. 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
15. Usually experience frequent urination?	0	1 2 3 4
16. 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
17. Usually experience urine leakage related to coughing, sneezing or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PFDI-20 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).

Questionnaire - Breathing

SEBQ - The Self Evaluation of Breathing Questionnaire

- 0** Never/not true at all
1 Occasionally/a bit true
2 Frequently-mostly true
3 Very frequently/very true

		0	1	2	3
1	I get easily breathless out of proportion to my fitness				
2	I notice myself breathing shallowly				
3	I get short of breath reading and talking				
4	I notice myself sighing				
5	I noticing myself yawning				
6	I feel I cannot get a deep or satisfying breath				
7	I notice that I am breathing irregularly				
8	My breathing feels stuck or restricted				
9	My ribcage feels tight and cannot expand				
10	I notice myself breathing quickly				
11	I get breathless when I'm anxious				
12	I find myself holding my breath				
13	I feel breathless in association with other physical symptoms				
14	I have trouble coordinating my breathing when I am speaking				
15	I can't catch my breath				
16	I feel that the air is stuffy, as if not enough air in the room				
17	I get breathless even when I am resting				
18	My breath feels like it does not go in all the way				
19	My breath feels like it does not go out all the way				
20	My breathing is heavy				
21	I feel that I am breathing more				
22	My breathing requires work				
23	My breathing requires effort				
24	I find myself breathing through my mouth during the day				
25	I breathe through my mouth at night while I sleep				
Totals					
A score greater than 11 may indicate problems with your breathing.		TOTAL			

Questionnaire - Sleep

Sleep Questionnaire - Please answer the following questions about your sleep

Do you snore?	Y	N	Do you wake unrefreshed?	Y	N
Have you noticed you stop breathing when you sleep?			Do you awaken with shortness of breath?		
Have you ever fallen asleep while driving?			In the daytime are you chronically sleepy fatigued or tired?		
Have you ever fallen asleep while operating machinery?			Do daytime worries keep you awake at night?		
Do you hold a commercial drivers licence? (Taxi, Truck etc)			Do you grind your teeth at night?		
Does pain disturb your sleep?			Do you kick or jerk your arms or legs at night?		
Do you experience unpleasant leg sensations at bed time?			Do you go to the toilet frequently at night? If yes, how many times on average? _____		
Have you ever had unusual movements or behaviours during sleep?			Do you take sleeping tablets? If yes, how often? __ Nightly __ as Necessary		

Additional questions - Stop - Bang

S - Do you SNORE loudly? (louder than talking or loud enough to be heard through closed doors?	Yes
T - Do you often feel TIRED in the day time?	
O - Has anyone OBSERVED you stop breathing in your sleep?	
P - Do you have or are you being treated for High Blood PRESSURE?	
B - Is your BMI greater than 35kg/M2	
A - AGE over 50 years old?	
N - Neck circumference greater than 43 cm Males, 41 cm females?	
G - Gender Male or post menopausal Female?	
Each positive response scores 1 point	Total score =

Epworth Sleepiness Scale Questionnaire - How likely are you to doze off or fall asleep in the following situations as opposed to feeling just tired. 0 = no chance 1 slight chance 2= moderate chance 3 = high chance

Sitting and reading				
Watching television				
Sitting inactive in a public place eg theatre or meeting				
A passenger in a car for an hour without a break				
Lying down in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic?				
Total Score = _____				

Questionnaire - Male Urinary Symptoms ICIQ-MLUTS 01/06 Short Form

Many people experience urinary symptoms some of the time. We are trying to find out how many people experience urinary symptoms, and how much they bother them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

1a. Is there a delay before you can start to urinate?	Never	0	Occasionally	1	Sometimes	2	Most of the time	3	All of the time	4
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1b. How much does this bother you? <i>Please ring a number between 0 (not at all) and 10 (a great deal)</i>										
0	1	2	3	4	5	6	7	8	9	10

2a. Do you have to strain to continue urinating?	Never	0	Occasionally	1	Sometimes	2	Most of the time	3	All of the time	4
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2b. How much does this bother you? <i>Please ring a number between 0 (not at all) and 10 (a great deal)</i>										
0	1	2	3	4	5	6	7	8	9	10

3a. Would you say that the strength of your urinary stream is...										
normal	0	occasionally reduced	1	sometimes reduced	2	reduced most of the time	3	reduced all of the time	4	

3b. How much does this bother you? <i>Please ring a number between 0 (not at all) and 10 (a great deal)</i>										
0	1	2	3	4	5	6	7	8	9	10

4a. Do you stop and start more than once while you urinate?	Never	0	Occasionally	1	Sometimes	2	Most of the time	3	All of the time	4
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4b. How much does this bother you? <i>Please ring a number between 0 (not at all) and 10 (a great deal)</i>										
0	1	2	3	4	5	6	7	8	9	10

5a. How often do you feel that your bladder has not emptied properly after you have urinated?	Never	0	Occasionally	1	Sometimes	2	Most of the time	3	All of the time	4
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5b. How much does this bother you? <i>Please ring a number between 0 (not at all) and 10 (a great deal)</i>										
0	1	2	3	4	5	6	7	8	9	10

6a. Do you have a sudden need to rush to the toilet to urinate?	Never	0	Occasionally	1	Sometimes	2	Most of the time	3	All of the time	4
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6b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
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7a. Does urine leak before you can get to the toilet?	Never	0	Occasionally	1	Sometimes	2	Most of the time	3	All of the time	4
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7b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
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8a. Does urine leak when you cough or sneeze?	Never	0	Occasionally	1	Sometimes	2	Most of the time	3	All of the time	4
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8b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
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9a. Do you ever leak for no obvious reason and without feeling that you want to go?	Never	0	Occasionally	1	Sometimes	2	Most of the time	3	All of the time	4
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9b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
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10a. Do you leak urine when you are asleep?	Never	0	Occasionally	1	Sometimes	2	Most of the time	3	All of the time	4
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10b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal) no, urine does not leak o

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

11a. How often have you had a slight wetting of your pants a few minutes after you had finished urinating and had dressed yourself?	Never	0	Occasionally	1	Sometimes	2	Most of the time	3	All of the time	4
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11b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
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12a. During the day, how many times do you urinate, on average?	1-6 times	0	7-8 times	1	9-10 times	2	11-12 times	3	13 times or more	4
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12b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
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13a. During the night, how many times do you have to get up to urinate, on average?

None	0	One	1	two	2	Three	3	Four or more	4
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13b. How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
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Questionnaire - Male Sexual Matters

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We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

1a. Do you get erections?	yes, with normal rigidity	0	yes, with reduced rigidity	1	yes, with severely reduced rigidity	2	no, erection not possible	3
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1b. How much of a problem is this for you?

Please ring a number between 0 (not a problem) and 10 (a serious problem)

0	1	2	3	4	5	6	7	8	9	10
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2a. Do you have an ejaculation of semen?	yes, normal quantity	0	yes, reduced quantity	1	yes, significantly reduced quantity	2	no ejaculation	3
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2b. How much of a problem is this for you?

Please ring a number between 0 (not a problem) and 10 (a serious problem)

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

3a. Do you have pain or discomfort during ejaculation?	no	0	yes, slight pain/discomfort	1	yes, moderate pain/discomfort	2	yes, severe pain/discomfort	3
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3b.. How much of a problem is this for you?

Please ring a number between 0 (not a problem) and 10 (a serious problem)

0	1	2	3	4	5	6	7	8	9	10
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4a. To what extent do you feel that your sex life has been spoilt by your urinary symptoms?	not at all	0	a little	1	somewhat	2	a lot	3
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4b.. How much of a problem is this for you?

Please ring a number between 0 (not a problem) and 10 (a serious problem)

0	1	2	3	4	5	6	7	8	9	10
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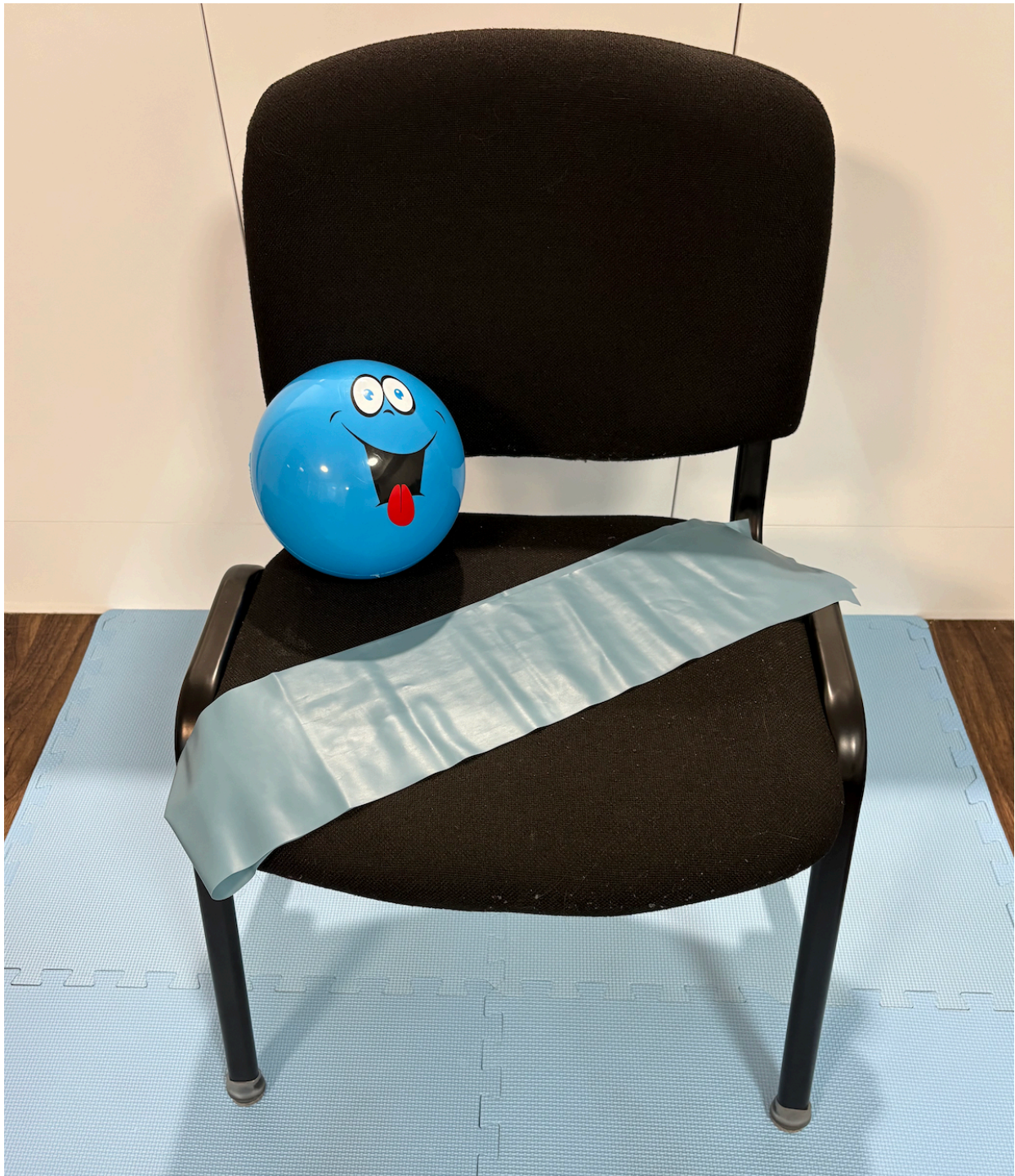
4c. If you have no sex life, how long ago did this stop?	years	months	
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Photos

<p>Standing from the front</p>	<p>Standing from the side</p>	<p>Standing from the back</p>
<p>Standing bent over with my arms hanging</p>		

My Waist Measurement = _____ on _____
 My Weight _____ on _____

Equipment needed



You will need a Yoga mat, Stretchy strap, Chair, Ball.

We will be standing, kneeling, bending, doing a lunge and lying down. If your movement is challenged you may also need a yoga block, cushion, or rolled towel, and if it is too difficult to lie on the floor you may want to lie on your bed for the lying down poses.

FAQ

1 What should I wear?	Wear something comfortable that allows you to move freely
2 How often should I do the class?	As a beginner we have found best results with doing a class 2-3 times a week. As your body adjusts to the exercises you can do more if you wish.
3 Do I have to be a patient of the practice to attend?	Not at all, but when you start working you may find you have areas of tightness that you weren't aware of... Chiropractic care will often help with that.
4 What about bottom burps?	Front and back bottom burps can happen as you begin to reconnect your pelvic floor. Again, these don't happen to everyone, but it is fine if they do. They usually decrease the more you practice.
5 Why do I feel emotional?	Breathing can be affected by highly emotional situations. When we start correcting bad habits emotions can be released. This does not happen to everyone, but is perfectly ok if it does for you.
6 I'm attending an in person class - where do I go?	To Alison's Chiropractic Practice at 52 Douglas Street, Milton

