Initials: _____ Date: _____

PELVIC HEALTH INTAKE FORM

General information

Name _____ Age _____ Weight _____ Height _____
Briefly describe the reason that brought you in today.
_____
_____
_____
_____

Rate the severity of the problem on a scale of 0 – 10. 0 is not a problem. 10 is it significantly affects quality of life. _____
If activities/events cause or aggravate your symptoms, check all that apply

- Sitting for _____ many minutes
- Standing for _____ many minutes
- Walking for _____ many minutes
- Changing positions
- Sexual intercourse
- Other _____
- No activity affects the problem

What, if anything, relieves your symptoms?
_____

Please rate your pain, if any, on a scale of 0 (no pain) – 10 (worst imaginable) _____.
Has the pain been getting

- Better
- Worse
- Staying the same

My pain is (check any that apply)

- Intermittent
- Constant
- Aching
- Sharp
- Shooting
- Cramping
- Throbbing
- Sore
- Burning
- Other _____

Initials: _____ Date: _____

Please indicate what you would like to achieve through therapy.

_____

_____

Please indicate any concerns you have about receiving therapy.

_____

_____

Are there any beliefs, values, rules, or customs that the therapist needs to consider when treating you?

_____

_____

Health History

Month/Year of last physical exam ____/____

Procedures and dates by any specialists:

_____

How would you rate your current overall physical health?

- Good
- Fair
- Poor

How would you rate your current stress level?

- Low
- Medium
- High

Occupation _____ Hours/week _____
Activity/Exercise _____ Times/week Type_____
Alcohol consumption? _____ alcoholic beverages/week _____
Cigarette smoking? _____

Initials: _____ Date: _____

Please circle the corresponding box to indicate if you have or have had any of the following conditions.

Fibromyalgia
Lupus
Lyme disease
Lymphedema
Obesity
Thyroid disorder
Low back pain
Sacroiliac disease
TMJ/neck pain
Rheumatoid arthritis
Osteoarthritis
Osteoporosis/osteopenia
Scoliosis
Headaches/migraines
Chronic fatigue syndrome
Multiple sclerosis
Ankle swelling
Seizures/epilepsy
Traumatic brain/head Injury
TIA/CVA/stroke
Alcohol/substance abuse
Psychiatric disorder
Anxiety/depression
Postpartum depression
Post traumatic stress disorder
Hepatitis
HIV/AIDS
Sexually transmitted disease
Physical/sexual trauma
Bowel/bladder dysfunction
Painful bladder
Leaking of urine or stool
Childhood bladder problems
Joint replacement
_____
Fractures - site
_____
Currently pregnant # of weeks _____
Kidney disease
Alzheimer's disease/dementia
High or low blood pressure
Irritable bowel syndrome
Anorexia/bulimia
Acid reflux/ulcers
Raynaud's (cold hand/feet)
Hernia
Heart disease
Emphysema/chronic bronchitis
Asthma/breathing disorders
Hearing loss/problems
Vision/eye problems
Latex sensitivity
Anemia
Diabetes
Cancer – type
_____
Other
_____

Indicate surgical history below by checking all that apply.

- Back/spine
- Hysterectomy
- Bones/joints
- Mastectomy
- Gallbladder/appendix removed
- Bladder/prostate
- Abdominal organs
- Hernia repair
- Other _____

Initials: _____ Date: _____

Female – Indicate history by completing all that apply

# of pregnancies _____
# of vaginal deliveries _____
# of c-sections _____
abortions/miscarriages _____
difficult childbirth _____

# of episiotomies _____
date menopause began _____
pelvic pain _____

vaginal dryness _____
painful vaginal penetration _____
painful periods _____
prolapse or organ falling out _____
Pelvic pain_____
shy bladder_____
other _____

Male – Indicate history by checking all that apply.
prostate disorders _____
painful ejaculation _____
erectile dysfunction _____
pelvic pain _____
shy bladder _____
other _____

List (or provide list of) all current prescription and over the counter medications/supplements, including start date, dosage, frequency, and reason for taking. Write on back, if needed.

_____

_____

List all allergies that you may have.

_____

Bladder and bowel

Check all that apply:

- Trouble initiating urine stream
- urinary intermittent/slow stream
- difficulty stopping urine stream
- trouble emptying bladder
- straining/pushing to empty bladder

Frequency of urination

- times per day during wakeful hours _____
- times per night during sleep hours _____

When you have a normal urge to urinate, how long are you able to delay before you have to use the toilet?

- minutes _____ hours ____

- I can't wait

The usual amount of urine passed is
- small
- medium
- large

Frequency of bowel movements
- times per day _____
- times per week _____
- other _____

When you have an urge to have a bowel movement, how long are you able to delay before you have to use the toilet?
- minutes _____
- hours _____
- I can't wait

If constipation is present, please describe management techniques
_____

Do you have the feeling of organ "falling out"/prolapse or pelvic heaviness/pressure?
- Yes
- With standing for _____ minutes or _____ hours
- With exertion
- With bowel movement
- No

Indicate average fluid intake (one cup is 8 oz) _____ cups/day
Indicate how many of these cups something other than water _____

Check all that apply

- trouble feeling bladder urge/fullness
- dribbling after urination
- constant urine leakage
- blood in urine
- painful urination
- pain with bowel movements
- trouble holding back gas/feces
- current laxative use
- recurrent bladder infections
- constipation/straining
- frequent abdominal bloating
- other _____

I am experiencing bladder leakage
- yes
- no
- only with physical exertion/cough

- Number of episodes ____ Times/day ____ Times/week _____ Times/month

On average, how much urine do you leak?

- a few drops
- wets underwear
- wets outerwear

I am experiencing bowel leakage.

- yes
- no
- only with exertion/strong urge
- Number of episodes ____ Times/day ____ Times/week _____ Times/month

On average, how much stool do you lose?

- stool staining
- small amount in underwear
- complete emptying

Indicate what form of protection you wear.

- none
- minimal (tissue/paper towel/panty shield)
- moderate (absorbent product/maxipad)
- maximum (specialty product/diaper)
- If needed, how many pad/protection changes are required in 24 hours _____

Initials: _____ Date: _____

Consent for evaluation and treatment

The term “informed consent” means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to the patient. 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, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand that to evaluate and treat my condition, it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination and/or internal treatment. This is done by observing and/or palpating the perineal region including the vagina and/or rectum to assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback. Treatment to the pelvic region **internally** may be necessary to fully reach desired results and obtain your personal goals of health and wellness. Treatment may include, but not be limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

I understand I have the option to decline an internal pelvic floor examination and internal treatment and acknowledge that declining the internal exam and treatment limits the therapist’s evaluation and ability to treat.

I consent to internal pelvic floor examinations/treatment. yes no

I choose to have a chaperone in the room during internal exams/treatment. yes no

I understand that if I have experienced past physical or emotional trauma related to the pelvic region, it is best to share this information with my treating therapist.

Patient Initials _____

Potential risks: I may experience an increase in my current level of pain or discomfort 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 therapist.

Potential benefits: 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.

No warranty: I understand that the physical 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

Initials: _____ Date: _____

her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

Plan of Care Agreement: I understand and agree to the following.

1. For optimum care and progress, it is important to keep all scheduled therapy appointments. At those visits, we may advance your exercise and home programs as indicated upon the visit. If it is necessary to cancel an appointment, provide at least 24 hours notice prior to the scheduled appointment time in order to avoid the $80 cancellation fee.
2. Wear comfortable clothing to all visits, or bring a change of clothes for comfort during exercise and treatment.
3. Bring any previous exercise sheets, logs, and questions about my current therapy and goals.

My diagnosis, evaluation findings, treatment program, expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program have been explained to me. I have informed my therapist of any condition that would limit my ability to have an evaluation or treatment. My questions about care have been answered to my understanding and satisfaction. I hereby request and consent to evaluation/treatment to be provided by the therapists and PT assistants of Comber Physical Therapy.

Patient name printed _____

Patient/Guardian signature _____ Date _____

Therapist signature _____ Date _____