Pelvic Health Patient History Intake Form

Describe the current problem that brought you here?

How many months ago did your problem first begin?

Was your first episode of the problem related to a specific incident? If yes, please describe and specify date

- ◯ No
- ◯ Yes

Since that time is it

- ◯ Staying the same
- ◯ Getting worse
- ◯ Getting better

Why or how?

Pelvic Health Patient History Intake Form

If pain is present, rate pain on a 0-10 scale, 10 being the worst

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Describe the nature of the pain (i.e. constant burning, intermittent ache)

Describe previous treatment/exercises

Activities/events that cause or aggravate your symptoms. Check all that apply

☐ Sitting for more than a certain number of minutes (specify number)

☐ Walking for more than a certain number of minutes (specify number)

☐ Standing for more than a certain number of minutes (specify number)

Pelvic Health Patient History Intake Form

Activities/events that cause or aggravate your symptoms. Check all that apply

- [ ] Sitting for more than a certain number of minutes (specify number)

- [ ] Walking for more than a certain number of minutes (specify number)

- [ ] Standing for more than a certain number of minutes (specify number)

- [ ] Changing positions (ie. - sit to stand)
- [ ] Light activity (light housework)
- [ ] Sexual activity
- [ ] With cough/sneeze/straining
- [ ] With laughing/yelling
- [ ] With lifting/bending
- [ ] With cold weather
- [ ] With triggers -running water/key in door
- [ ] With nervousness/anxiety
- [ ] No activity affects the problem
- [ ] Other (please specify)

What relieves your symptoms?

Pelvic Health Patient History Intake Form

Has your lifestyle/quality of life been altered/changed because of this problem? Select all that apply and provide additional information

- [ ] Social activities (exclude physical activities)
- [ ] Diet /Fluid intake
- [ ] Physical activity
- [ ] Work
- [ ] Other

Please provide more details for any of the above you've checked off.

Rate the severity of this problem from 0 -10, with 0 being no problem and 10 being the worst

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

What are your treatment goals/concerns? *

Pelvic Health Patient History Intake Form

Since the onset of your current symptoms have you had: (select all that apply)

- [ ] Fever/Chills
- [ ] Unexplained weight change
- [ ] Dizziness or fainting
- [ ] Change in bowel or bladder functions
- [ ] Malaise (Unexplained tiredness)
- [ ] Unexplained muscle weakness
- [ ] Night pain/sweats
- [ ] Numbness / Tingling
- [ ] Other (please describe)

Please provide more details.

What was the date of your last physical exam?

What tests were performed during the exam?

How would you describe your general health?

- ◯ Excellent
- ◯ Good
- ◯ Average
- ◯ Fair
- ◯ Poor

Pelvic Health Patient History Intake Form

What is your occupation? Are you on disability or leave?

How would you describe your current level of stress?

- ◯ High
- ◯ Medium
- ◯ Low

Are you currently receiving psych therapy?

- ◯ Yes
- ◯ No

How often do you exercise?

- ◯ None
- ◯ 1-2 days/week
- ◯ 3-4 days/week
- ◯ 5+ days/week

Describe the type of activity/exercise you engage in

Pelvic Health Patient History Intake Form

Have you ever had any of the following conditions or diagnoses? Select all that apply:

- [ ] Cancer
- [ ] Stroke
- [ ] Emphysema/chronic bronchitis
- [ ] Heart problems
- [ ] Epilepsy/seizures
- [ ] Asthma
- [ ] High blood pressure
- [ ] Multiple sclerosis
- [ ] Allergies-list below
- [ ] Ankle swelling
- [ ] Head injury
- [ ] Latex sensitivity
- [ ] Anemia
- [ ] Hypothyroid/hyperthyroid
- [ ] Low back pain
- [ ] Chronic fatigue syndrome
- [ ] Headaches
- [ ] Sacroiliac/tailbone pain
- [ ] Fibromyalgia
- [ ] Diabetes
- [ ] Alcoholism/drug problem
- [ ] Arthritic conditions
- [ ] Kidney disease
- [ ] Childhood bladder problems
- [ ] Stress fracture
- [ ] Irritable bowel syndrome
- [ ] Depression
- [ ] Rheumatoid arthritis
- [ ] Hepatitis
- [ ] HIV/AIDS

Pelvic Health Patient History Intake Form

- [ ] Anorexia/bulimia
- [ ] Joint replacement
- [ ] Sexually transmitted disease
- [ ] Smoking history
- [ ] Bone fracture
- [ ] Physical or sexual abuse
- [ ] Vision/eye problems
- [ ] Sports injuries
- [ ] Raynaud's (cold hands and feet)
- [ ] Hearing loss/problems
- [ ] TMJ/neck pain
- [ ] Pelvic pain
- [ ] Fibromyalgia
- [ ] Other (please describe)

If other, please provide more details.

Have you ever had any of the following conditions or diagnoses? Select all that apply:

- [ ] Surgery for your back/spine
- [ ] Surgery for your bladder/prostate
- [ ] Surgery for your brain
- [ ] Surgery for your bones/joints
- [ ] Surgery for your female organs
- [ ] Surgery for your abdominal organs
- [ ] Other (please describe)

If other, please provide more details.

Pelvic Health Patient History Intake Form

Ob/Gyn History (females only) - select all that apply

- [ ] Childbirth vaginal deliveries (specify number)
- [ ] Episiotomy (specify number)
- [ ] C-Section (specify number)
- [ ] Difficult childbirth (specify number)
- [ ] Prolapse or organ falling out
- [ ] Vaginal dryness
- [ ] Painful periods
- [ ] Menopause (specify when)
- [ ] Pelvic pain
- [ ] Other (please describe)

Please provide more details for any of the above you've checked off.

For males, do you suffer from any of the following? (select all that apply)

- [ ] Prostate disorders
- [ ] Shy bladder
- [ ] Pelvic pain
- [ ] Erectile dysfunction
- [ ] Painful ejaculation
- [ ] Other (please describe)

If other, please provide more details.

Please list the medications (pills, injection, patch) that you take with the start date and the reason for taking

Pelvic Health Patient History Intake Form

Please list the over the counter drugs (vitamins, etc...) that you take with the start date and the reason for taking

Do you suffer from any of the following? (select all that apply)

- [ ] Trouble initiating urine stream
- [ ] Urinary intermittent /slow stream
- [ ] Trouble emptying bladder
- [ ] Difficulty stopping the urine stream
- [ ] Trouble emptying bladder completely
- [ ] Straining or pushing to empty bladder
- [ ] Dribbling after urination
- [ ] Constant urine leakage
- [ ] Blood in urine
- [ ] Painful urination
- [ ] Trouble feeling bladder urge/fullness
- [ ] Current laxative use
- [ ] Trouble feeling bowel/urge/fullness
- [ ] Constipation/straining
- [ ] Trouble holding back gas/feces
- [ ] Recurrent bladder infections
- [ ] Other (please describe)

If other, please provide more details.

Pelvic Health Patient History Intake Form

How often do you urinate during awake hours?

How often do you urinate during sleep hours?

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?

- ◯ Minutes
- ◯ Hours
- ◯ Not at all

The usual amount of urine passed is:

- ◯ Small
- ◯ Medium
- ◯ Large

How many times per day do you have a bowel movement?

How many times per week do you have a bowel movement?

Pelvic Health Patient History Intake Form

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?

- ◯ Minutes
- ◯ Hours
- ◯ Not at all

If you suffer from constipation, please describe your management techniques

What is your average fluid intake in glasses per day (one glass is 8 oz or one cup)?

Of this total, how many glasses are caffeinated?

Pelvic Health Patient History Intake Form

How often do you get a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

- ◯ None present
- ◯ A few times per month (specify frequency and if related to activity or your period)

Please provide more details.

- ◯ With standing for a number of minutes or hours (specify the number of minutes or hours)

Please provide more details.

- ◯ With exertion or straining
- ◯ Other

How often do you suffer from bladder leakage?

- ◯ No leakage
- ◯ Few times per day (specify frequency)

Please provide more details.

- ◯ Few times per week (specify frequency)

Please provide more details.

- ◯ Few times per month (specify frequency)

Please provide more details.

- ◯ Other

Pelvic Health Patient History Intake Form

How often do you suffer from bowel leakage?

- ◯ No leakage
- ◯ Few times per day (specify frequency)

Please provide more details.

- ◯ Few times per week (specify frequency)

Please provide more details.

- ◯ Few times per month (specify frequency)

Please provide more details.

- ◯ Other

On average, how much urine do you leak?

- ◯ No leakage
- ◯ Just a few drops
- ◯ Wets underwear
- ◯ Wets outerwear
- ◯ Wets the floor

On average, how much urine do you leak?

- ◯ No leakage
- ◯ Stool staining
- ◯ Small amount in underwear
- ◯ Complete emptying

Pelvic Health Patient History Intake Form

On average, how much urine do you leak?

- ◯ None
- ◯ Minimal protection (Tissue paper/paper towel/pantishields)
- ◯ Moderate protection (absorbent product, maxipad)
- ◯ Maximum protection (Specialty product/diaper)
- ◯ Other

If other, please provide more details.

On average, how many pad/protection changes are required in 24 hours?