

# PELVIC HEALTH INTAKE FORM

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Briefly describe the problem that brought you in today, how it began, and when. \_\_\_\_\_

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 OR ☐ no activity affects the problem

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> sitting more than _____ minutes   | <input type="checkbox"/> light activity (light housework)         | <input type="checkbox"/> with nervousness/anxiety |
| <input type="checkbox"/> walking more than _____ minutes   | <input type="checkbox"/> vigorous activity (run/jump/weight lift) | <input type="checkbox"/> with cold weather        |
| <input type="checkbox"/> standing more than _____ minutes  | <input type="checkbox"/> with coughing/sneezing/straining         | <input type="checkbox"/> with lifting/bending     |
| <input type="checkbox"/> changing positions (sit to stand) | <input type="checkbox"/> with trigger - running water/key in door | <input type="checkbox"/> with laughing/yelling    |
| <input type="checkbox"/> sexual intercourse                | <input type="checkbox"/> other activities _____                   |   |

What, if anything, relieves your symptoms? \_\_\_\_\_

If pain is present, please rate on a scale of 0 – 10. 0 is no pain. 10 is worst pain you can imagine. \_\_\_\_\_

Where did your pain begin? \_\_\_\_\_ Since it started, pain is ☐ worse ☐ better ☐ same

Current level of pain \_\_\_\_\_ Worst level of pain in last three days \_\_\_\_\_ Best level of pain in last three days \_\_\_\_\_

My pain is ☐ intermittent ☐ constant ☐ aching ☐ shooting ☐ sharp ☐ cramping ☐ throbbing  
☐ squeezing ☐ dull ☐ stabbing ☐ sore ☐ burning ☐ other \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

Have you had similar problems/symptoms in the past? ☐ yes ☐ no When? \_\_\_\_\_

Was your first episode of the problem related to a specific incident? ☐ yes ☐ no Explain \_\_\_\_\_

Since that time, the problem is ☐ staying the same ☐ getting worse ☐ getting better

Why or how? \_\_\_\_\_

Describe previous treatment/exercises. \_\_\_\_\_

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? \_\_\_\_\_

## PELVIC HEALTH INTAKE FORM

Month/Year of last physical exam \_\_\_\_/\_\_\_\_ Tests performed \_\_\_\_\_

Indicate dates of exams with specialists (urologists, gastroenterologists, ob/gyns) \_\_\_\_\_

How would you rate your current overall physical health? ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Rate your current level of stress. ☐ low ☐ medium ☐ high Current psychiatric therapy ☐ yes ☐ no

Occupation \_\_\_\_\_ Hours/week \_\_\_\_\_ Activity/Exercise \_\_\_\_\_ Times/week Type \_\_\_\_\_

Alcohol consumption ☐ yes ☐ no \_\_\_\_\_ alcoholic beverages/week Cigarette smoking ☐ yes ☐ no ☐ in the past

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

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

Indicate surgical history below by checking all that apply.

☐ back/spine    ☐ hysterectomy    ☐ bones/joints    ☐ mastectomy    ☐ gallbladder/appendix removed  
☐ brain    ☐ bladder/prostate    ☐ abdominal organs    ☐ hernia repair    ☐ other \_\_\_\_\_

**Female** – Indicate history by checking all that apply.

☐ # of vaginal deliveries \_\_\_\_\_    ☐ # of c-sections \_\_\_\_\_    ☐ vaginal dryness    ☐ painful vaginal penetration  
☐ # of episiotomies \_\_\_\_\_    ☐ difficult childbirth    ☐ painful periods    ☐ prolapse or organ falling out  
☐ date menopause began \_\_\_\_\_    ☐ pelvic pain    ☐ other \_\_\_\_\_

**Male** – Indicate history by checking all that apply.

☐ prostate disorders    ☐ painful ejaculation    ☐ pelvic pain    ☐ shy bladder  
☐ erectile dysfunction    ☐ 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. \_\_\_\_\_

## PELVIC HEALTH INTAKE FORM

### BLADDER AND BOWEL SYMPTOMS

Please check any of the pelvic symptoms you are experiencing.

<input type="checkbox"/> trouble initiating urine stream	<input type="checkbox"/> trouble feeling bladder urge/fullness	<input type="checkbox"/> trouble holding back gas/feces
<input type="checkbox"/> urinary intermittent/slow stream	<input type="checkbox"/> dribbling after urination	<input type="checkbox"/> current laxative use
<input type="checkbox"/> difficulty stopping urine stream	<input type="checkbox"/> constant urine leakage	<input type="checkbox"/> recurrent bladder infections
<input type="checkbox"/> trouble emptying bladder	<input type="checkbox"/> blood in urine	<input type="checkbox"/> constipation/straining
<input type="checkbox"/> trouble emptying bladder completely	<input type="checkbox"/> painful urination	<input type="checkbox"/> frequent abdominal bloating
<input type="checkbox"/> straining/pushing to empty bladder	<input type="checkbox"/> pain with bowel movements	<input type="checkbox"/> other _____

Frequency of urination **Awake hours** \_\_\_\_\_ times per day **Sleep hours** \_\_\_\_\_ times per night

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

\_\_\_\_\_ minutes \_\_\_\_\_ hours or ☐ 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 or ☐ 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 ☐ no

☐ with standing for \_\_\_\_\_ minutes or \_\_\_\_\_ hours ☐ with exertion/straining ☐ other \_\_\_\_\_

Indicate average fluid intake (one cup is 8 oz) \_\_\_\_\_ cups/day Indicate how many of these cups are caffeinated \_\_\_\_\_

### IF NOT EXPERIENCING LEAKAGE OR INCONTINENCE OF BLADDER OR BOWEL, PLEASE SKIP THIS SECTION.

<p>I am experiencing bladder leakage. <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> only with physical exertion/cough</p> <p>Number of episodes _____ Times/day _____ Times/week _____ Times/month</p> <p>On average, how much urine do you leak? <input type="checkbox"/> a few drops <input type="checkbox"/> wets underwear <input type="checkbox"/> wets outerwear <input type="checkbox"/> wets floor</p>
<p>I am experiencing bowel leakage. <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> only with exertion/strong urge</p> <p>Number of episodes _____ Times/day _____ Times/week _____ Times/month</p> <p>On average, how much stool do you lose? <input type="checkbox"/> stool staining <input type="checkbox"/> small amount in underwear <input type="checkbox"/> complete emptying</p>
<p>Indicate what form of protection you wear. <input type="checkbox"/> none <input type="checkbox"/> minimal (tissue/paper towel/panty shield)</p> <p><input type="checkbox"/> moderate (absorbent product/maxipad) <input type="checkbox"/> maximum (specialty product/diaper)</p> <p>Indicate, on average, how many pad/protection changes are required in 24 hours. _____ # of pads</p>

## PELVIC HEALTH INTAKE FORM

### CONSENT FOR EVALUATION AND TREATMENT (page 1)

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 understand I may choose to have another clinical employee in the room during an internal portion of the exam.

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

I understand that I can change the options selected above at any time by completing a new Consent for Evaluation and Treatment.

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 \_\_\_\_\_

## PELVIC HEALTH INTAKE FORM

### CONSENT FOR EVALUATION AND TREATMENT (page 2)

**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.

**Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

**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 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 \$50 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, biofeedback sensors (if issued), and questions I 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 \_\_\_\_\_