

Patient History

Name _____ DOB _____ Date _____

1. Describe the current problem that brought you here: _____

2. When did your problem first begin? _____

3. Was your first episode of the problem related to a specific incident? **Yes / No**

Please describe and specify date _____

4. Since that time is it staying the *(circle one)* **SAME** **GETTING WORSE** **GETTING BETTER**
Why or how? _____

5. Please rate present/current pain. (0 = no pain, 10 = Worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

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

7. Describe previous treatment/exercises _____

8. Activities/events that cause or aggravate your symptoms. *(check/circle all that apply)*

- | | |
|--|--|
| ☐ Sitting greater than _____ minutes | ☐ With cough/sneeze/straining |
| ☐ Walking greater than _____ minutes | ☐ With laughing/yelling |
| ☐ Standing greater than _____ minutes | ☐ With lifting/bending |
| ☐ Changing positions (i.e. sit to stand) | ☐ With cold weather |
| ☐ Light activity (i.e. light housework) | ☐ With triggers |
| ☐ Vigorous activity/exercise (i.e. run/lift/jump) | ☐ With nervousness/anxiety |
| ☐ Sexual activity | ☐ No activity affects the problem |
| ☐ Other, please list _____ | |

Name _____ Date _____

15. Have you ever had any of the following conditions/diagnoses? *(circle all that apply)*

Ankle Swelling	Arthritic Conditions	Irritable Bowel Syndrome
Low Back Pain	Stress Fracture	Sexually Transmitted Disease
Sacroiliac/Tailbone Pain	Acid Reflux	Physical or Sexual Abuse
Childhood Bladder Problems	Joint Replacement	Raynaud's (cold hands/feet)
Anorexia/Bulimia	Bone Fracture	Pelvic Pain
Multiple Sclerosis	TMJ/Neck Pain	Kidney Disease
Head Injury	Emphysema/Chronic Bronchitis	Fibromyalgia
Chronic Fatigue Problem	Asthma	Latex Sensitivity
Cancer	Heart Problems	High Blood Pressure
Anemia	Alcoholism/Drug Problems	Depression
Anxiety	Smoking History	Vision/Eye Problems
Hearing Loss/Problems	Stroke	Epilepsy/Seizures
Osteoporosis	Allergies	Hypothyroid/Hyperthyroid
Headaches	Diabetes	Hepatitis/Liver Problems
Respiratory/Breathing	Gastrointestinal	Blood Clots
Gout	Autoimmune	Sports Injury

Other, describe _____

16. OB/GYN History *(females only)*

Yes / No Pregnancies # _____	Yes / No Vaginal dryness
Yes / No Deliveries # _____	Yes / No Painful periods
Type of Delivery: Vaginal # _____ C-Section # _____	Yes / No Menopause, when? _____
Yes / No Difficult Childbirth # _____	Yes / No Painful vaginal penetration
Yes / No Prolapse or organ falling out	Yes / No Pelvic/genital pain
Yes / No Other, describe _____	

17. History *(males only)*

Yes / No Prostate disorders	Yes / No Erectile dysfunction
Yes / No Shy bladder	Yes / No Painful ejaculation
Yes / No Pelvic/genital pain location _____	
Yes / No Other, describe _____	



Physical Therapy Services

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18. Medications (*pills, injections, patch, etc.*) Include name, start date, and reason for taking.

19. Over the counter, Vitamins, etc. Include name, start date, and reason for taking.

20. Allergies, including reactions.

21. General Health (*circle one*)

Excellent

Good

Average

Fair

Poor

22. Activity/Exercise (*circle one*)

None

1-2 days/week

3-4 days/week

5+ days/week

Describe _____

23. Mental Health: Current levels of stress ____ **High** ____ **Medium** ____ **Low**

Current psych therapy? **Yes / No**

Date of last physical exam _____ Tests performed _____

Name _____ Date _____

Pelvic Symptom Questionnaire

Bladder/Bowel Habits/Symptoms

- | | |
|--|--|
| Yes / No Trouble initiating urine stream | Yes / No Constant urine leakage |
| Yes / No Urinary intermittent/slow stream | Yes / No Trouble feeling bladder urge/fullness |
| Yes / No Strain or push to empty bladder | Yes / No Recurrent bladder infections |
| Yes / No Trouble emptying bladder completely | Yes / No Painful urination |
| Yes / No Difficulty stopping the urine stream | Yes / No Blood in stool/feces |
| Yes / No Blood in the urine | Yes / No Painful bowel movements |
| Yes / No Dribbling after urination | Yes / No Trouble feeling bowel urge/fullness |
| Yes / No Seepage/loss of bowel movement w/o awareness | Yes / No Trouble controlling bowel urge |
| Yes / No Trouble holding back gas/feces | Yes / No Trouble emptying bowel completely |
| Yes / No Need to support/touch to complete bowel movement | Yes / No Staining of underwear after bowel movement |
| Yes / No Constipation/straining _____ % of the time | Yes / No Current laxative use _____ |
| Yes / No Other, describe _____ | |

- Frequency of urination: while awake _____ times per day, during sleep waking _____ times per night.
- 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.
- Frequency of bowel movements _____ times per day or _____ times per week.
- The bowel movements typically are: watery _____ loose _____ formed _____ pellets _____ other _____
- 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 constipation is present, describe management techniques _____
- Average fluid intake (*one glass is 8oz or 1cup*) _____ glasses per day. Of this total, how many are caffeinated? _____ glasses per day.
- Rate the feeling of organ "falling out"/prolapse or pelvic heaviness/pressure:

None	_____ Times per month (specify if	With standing for _____ minutes	With exertion or
Present	related to menstrual cycle)	or _____ hours	straining
			Other _____

Bladder Leakage – number of episodes

No Leakage

_____ Times per day

_____ Times per week

_____ Times per month

Only with physical exertion/cough

On average, how much urine do you leak?

No Leakage

Just a few drops

Wets underwear

Wets outerwear

Wets floor

Bowel leakage – number of episodes

No Leakage

_____ Times per day

_____ Times per week

_____ Times per month

Only with exertion/strong urge

How much stool do you lose?

No Leakage

Stool staining

Small amount in underwear

Complete emptying

Other _____

10. What form of protection do you wear? (Absorbent products, Pads, Diapers, etc.) _____

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

INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION

During the physical therapy evaluation for the problems you have reported, an assessment of your low back, hips, and pelvic girdle will be performed by a physical therapist in order to identify any musculoskeletal problems. This may include an evaluation of your pelvic floor muscles for strength, resting tone (tightness), and coordination (contract/relax). The findings will be discussed with you, and you will work with your physical therapist to develop a treatment plan that is appropriate for YOU.

Your evaluation MAY include an INTERNAL assessment of the pelvic floor muscles, which could be completed vaginally (females) or rectally (males & females).

A biofeedback assessment of your pelvic floor muscles may also be performed and may include internal or external sensors. Your physical therapist will discuss this option and receive your consent BEFORE initiating the exam.

You can absolutely say NO, and your physical therapist can assess and treat the pelvic floor muscles externally (from the outside) if needed. The assessment of the pelvic floor muscles may result in soreness or discomfort temporarily. If this occurs, please discuss your symptoms with your physical therapist.

We realize that many patients may be apprehensive because of the private nature of the condition and the examination. Please ask as many questions as you need to increase your comfort and understanding of your evaluation, its findings, and treatment. Please discuss any concerns or hesitations that you may have with your physical therapist.

By signing this form, you agree and understand the treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat as discussed. You are always free to change your mind at any time during your course of treatment, and you are encouraged to notify your physical therapist of any changes of your preferences.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment (as described above). The second person could be a friend, family member, or clinic staff member. Please indicate your preference with your initials:

_____ **YES** I want a second person present during the pelvic floor muscle evaluation and treatment.

_____ **NO** I do not want a second person during the pelvic floor muscle evaluation and treatment.

CONSENT

I have read and understand the INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION, and I consent to the evaluation and treatment, unless other noted below.

Patient Name *(printed)* _____

Patient Signature _____ Date _____

Please list any exceptions to consent – if none, write none.

