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Pelvic Health and Past Medical History Intake Form

Patient Name:____________________________ Date of Birth:___________ Age:________

Referring Physician:______________________ Diagnosis:____________________________

Emergency Contact name and Phone#:____

1. Describe the Current problem that brought you to seek physical therapy:

____

____

____

2. When did your problem first begin? (approximate date or exacerbation):_____________________

3. If pain is present, rate pain on a scale of 0-10 (10 being the worst) ____/10

Describe the location of the pain ____

Check the words that describe your pain:

☐Hot	☐Deep Aching	☐Cold	☐Unbearable
☐Burning	☐Stabbing	☐Itching	☐Annoying
☐Sharp	☐Radiating	☐Tearing	☐Other_________________
☐Dull	☐Electric	☐Fatiguing	

What activities cause pain? ____

4. What treatments have you had for this problem?____

____

5. What do you hope to achieve with Physical Therapy?____

____

Health History

Date of last Physical:_____________ Date of last Pelvic/Prostate exam:_______________

General Health: ☐Excellent ☐Good ☐Average ☐Fair ☐Poor

Current Level of stress: ☐High ☐Medium ☐Low

Activity/Exercise Level: ☐None ☐1-2 days/week ☐3-4 days/week ☐5+ day

Do you work? ☐ Yes ☐ No What's your occupation?__________________________________

Patient Name:________________________

Date of Birth:________________________

Medical History: Have you ever had any of the following conditions or Diagnoses? Check all that apply

☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Angina/Chest Pain
☐ Anemia
☐ Stroke/CVA
☐ Asthma
☐ Arthritis/Gout
☐ Interstitial Cystitis
☐ Hepatitis/Jaundice
☐ Parkinson's Disease
☐ Emphysema/COPD
☐ Osteoporosis/Osteopenia
☐ Fibromyalgia
☐ Hypothyroid/Hyperthyroid
☐ Multiple Sclerosis
☐ Epilepsy/seizures
☐ Hypoglycemia
☐ Neurological Disorders
☐ Latex Sensitivity
☐ Headaches
☐ Fractures
☐ Irritable Bowel Syndrome
☐ Incontinence Bladder/bowel
☐ Sexually Transmitted disease
☐ Pelvic Pain
☐ Physical or sexual abuse
☐ Vertigo or Dizziness
☐ Kidney Disorder

☐ Other____

ALLERGIES:____

Medications: (Including over the counter and supplements) ☐ NONE

____

____

____

____

Surgical History/Procedures: (include month/year of occurrence) Check all that Apply

☐ Surgery for Back/spine:____

☐ Surgery for Abdominal organs:____

☐ Surgery for Female organs:____

☐ Surgery for Bladder/Prostate:____

☐ Other:____

Patient Name:_______________________

Date of Birth:_______________________

OB/GYN History: (include month/year of occurrence) **Females only. Check all that apply:**

☐Date of Last Pelvic Exam__________ ☐Are you currently pregnant?________________

☐Number of Pregnancies_________ ☐Number of miscarriages___________

☐Vaginal deliveries__________________________ ☐Birth weight of largest baby________________

☐Episiotomy_______________________________ ☐Vaginal tearing___________________________

☐C-section________________________________ ☐History of Sexual abuse or trauma

☐Complications with Labor____

☐Are you undergoing any infertility treatment?______________________________________

☐Painful Periods ☐Vaginal Dryness ☐Pelvic Pain

☐Menopause-When? _____________________________ ☐Prolapse or organ falling out

☐Other/describe____

Male Pelvic History: (Include month/year of occurrence) **Males Only. Check all that apply:**

☐Prostate disorders__________________ ☐Erectile Dysfunction_______________________

☐Shy Bladder________________________ ☐Painful ejaculation________________________

☐Pelvic/Rectal Pain___________________ ☐History of sexual abuse or trauma

☐Other/describe____

Bladder Symptoms: Check all that apply

☐Lose Urine with Cough/Sneeze/Laugh ☐Lose urine with Jog/exercise/jump

☐Lose Urine on the way to bathroom ☐Lose urine with triggers (running water, key in door)

☐Have strong urge to urinate ☐Do you wet the bed

☐Have difficulty initiating urine stream ☐Intermittent or slow urine stream

☐Painful urination or burning ☐Unable to fully empty bladder

☐Pain with a full bladder ☐Strain to empty bladder

☐Dribble after urination ☐Urinate > 7 times per day

Patient Name:________________________

Date of Birth:________________________

Bladder Symptoms (cont):

How often do you urinate during the day? _________times per day

How often do you urinate at night? __________times per night

Do you leak urine? If so, how many episodes or times ______ per day, _______per week ☐No leakage

If leak urine, how much? ☐Just a few drops ☐wets underwear ☐wets outerwear

Do you wear protection? What form/type (pad, diaper, etc)____

My problem affects my quality of life in the following ways:

☐Social ☐Sleep ☐Job/work ☐Physical activity or exercise ☐Travel ☐Intimacy

Bowel Symptoms: Check all that Apply

☐Strain to have a Bowel Movement

☐Leak/stain feces

☐Leak gas by accident

☐Include fiber in your diet

☐Have strong urge to move bowels

☐Incomplete emptying of stool

☐Pain with Bowel Movement

☐Take laxatives/enema regularly

☐Have diarrhea often

☐Cannot defer urge to move bowels

How often do you move your bowels? ______________________times per day _________per week

Most Common stool consistency? ☐Liquid ☐soft but formed ☐Firm ☐Pellets ☐other______________

If Constipation is present describe management techniques?____

If Fecal incontinence/stool leakage, how many ______times per day, __________times per week? ☐No leakage

Average Fluid intake (one glass is 8 oz or 1 cup) ________________glasses per day.

How many glasses are water? _________glasses How many are caffeinated drinks? _______ glasses

My problem affects my quality of life in the following ways:

☐Social ☐Sleep ☐Job/work ☐Physical activity or exercise ☐Travel ☐Intimacy

____ ______________________________

Patient signature or Patient's Legal representative/Guardian/parent Date

____ ______________________________

Therapist Signature Date