Pelvic Health Patient Intake Form

Name: _____ Date: _____

Please answer the following questions as honestly and thoroughly as you can. Your responses will help us better understand your condition and provide the best quality of care.

For which symptom(s) are you seeking treatment?

URINARY
- ❑ Incontinence (bladder control, involuntary loss of urine)
- ❑ Urgency (overwhelmingly strong urge to urinate)
- ❑ Frequency (too frequent voiding)

BOWEL
- ❑ Incontinence (bowel control)
- ❑ Problem with Bowel Emptying
- ❑ Problem with Bowel Urgency

OTHER
- ❑ Pelvic Organ Prolapse (bulge or protrusion into the vagina)
- ❑ Pelvic Pain

How long have you had the above problem(s)? _____
What treatments have you tried? _____
Have you had any tests or imaging? Urodynamic / Cystoscope / Ultrasound / MRI / Colonoscopy / Other
Have you had any back, hip, sacral, or pelvic injuries? _____
_____
Have you had any back, hip, or pelvic surgeries? _____
_____
Do you currently have any back, hip, or pelvic pain? YES / NO

Bladder Symptoms

How many times per day do you urinate? _____
How many times do you get up to urinate during the night? _____
Do you have difficulty starting urination? YES / NO
Do you strain or push to urinate? YES / NO
Is your urine flow weak or intermittent? YES / NO
Do you leak immediately after voiding (upon standing or as you walk away from the toilet)? YES / NO
Do you feel like you fully empty your bladder? YES / NO
Do you get frequent bladder infections? YES / NO
Are you able to stop your flow of urine intentionally? YES / NO / NEVER TRIED

Urine Leakage

How often do you leak?
- ❑ Never

How much urine do you think you leak?
- ❑ None

❑ About once a week or less
❑ Two or three times a week
❑ About once a day
❑ Several times a day
❑ All of the above

❑ A small amount
❑ A moderate amount
❑ A large amount

Overall, how much does leaking urine interfere with your everyday life?

0	1	2	3	4	5	6	7	8	9	10
(not at all)										(a great deal)

How many pads do you use per day? _____

Do you associate any of the following activities with urine loss?

❑ Coughing ❑ Sneezing ❑ Laughing ❑ Jumping
❑ Sit to stand ❑ Bending ❑ Exercise ❑ Sleeping
❑ Lifting ❑ Anxiety/Stress ❑ Intercourse

Bowel Symptoms

Have you ever seen blood in your stool? YES / NO

How many bowel movements do you have? Per day _____ per week _____

Which bowel symptom(s) do you experience?

❑ Loose stool ❑ Fecal incontinence
❑ Normal stool ❑ Unable to control gas
❑ Constipation ❑ Strain to pass stool

Do you get a strong sense of urgency to have a bowel movement? YES / NO

Do you feel your bowels are completely empty after you have a bowel movement? YES / NO

Do you lose stool unintentionally if your stool is loose? YES / NO …is well formed? YES / NO

Do you take any fiber supplements, laxatives, or stool softeners? _____
_____

Sexual Symptoms

Are you sexually active? YES / NO

Do you have any sexually transmitted diseases? YES / NO

If yes, please list: _____

Do you experience any pain, dysfunction, or discomfort with sexual activity? YES / NO

Have you ever been forced to engage in sexual activity against your will? YES / NO

Marital Status: _____

Do you feel safe in your current relationship? YES / NO

Pain

If you have pain related to the condition you are seeking treatment for, please indicate the severity of the pain.

0 1 2 3 4 5 6 7 8 9 10
(no pain) (the worst pain you can imagine)

Where is the pain? _____
Please describe the type of pain (sharp, burning, ache, etc.) _____

Obstetric Health

How many pregnancies have you had? _____
How many children have you given birth to? _____ Vaginal _____ Cesarean _____
Did any of your deliveries include:
❑ Tearing ❑ Forceps ❑ Episiotomy ❑ Vacuum Delivery ❑ Baby 8.5 lbs+
❑ Prolonged Second Phase ❑ Other: _____

Menstrual History

When was your first period? _____
Are you pregnant? YES / NO
Do you use birth control? YES / NO
If yes, what type? _____
Are you going through, or have you gone through, menopause? YES / NO
Are you using any hormone replacement? YES / NO
If yes, what type? _____

General

What is your occupation / what activities fill most of your time? _____
_____
What is your current activity level?
❑ Sedentary ❑ Light ❑ Moderate ❑ Heavy
What do you do for exercise? _____
Do you have any allergies to latex, tape, or other topicals? _____
What activities/events cause or aggravate your symptoms: Check all that apply:
❑ Sitting greater than ___minutes
❑ Walking greater than ___minutes
❑ Standing greater than___ minutes
❑ Changing positions (i.e., sit to stand)
❑ Light activity (light housework)
❑ Vigorous activity/exercise (run/weight lift/jump)
❑ No activity affects the problem
❑ With cough/sneeze/straining
❑ With laughing/yelling
❑ With cold weather
❑ With triggers (i.e., key in door, running water)
❑ With nervousness/anxiety
❑ Sexual activity
❑ Other, please list_____
What relieves your symptoms? _____
_____
How has your lifestyle/quality of life been altered/changed because of this problem?
❑ Social activities (exclude physical activities), specify _____

❑ Diet/Fluid intake, specify _____
❑ Physical activity, specify _____
❑ Work, specify _____
❑ Other _____

Since the onset of your current symptoms have you had

- ❑ Fever/chills
- ❑ Unexplained weight loss/gain
- ❑ Dizziness or fainting
- ❑ Change in bowel or bladder function
- ❑ Unexplained tiredness
- ❑ Unexplained muscle weakness
- ❑ Night pain/sweats
- ❑ Numbness/tingling

How would you rate your current stress level? HIGH / MEDIUM / LOW

Are you currently participating in psych therapy? YES / NO

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

- ❑ Cancer
- ❑ Heart problems
- ❑ High blood pressure
- ❑ Ankle swelling
- ❑ Anemia
- ❑ Low back pain
- ❑ Sacroiliac/Tailbone pain
- ❑ Alcoholism/drug problem
- ❑ Childhood bladder problems
- ❑ Depression
- ❑ Anorexia/ Bulimia
- ❑ Smoking history
- ❑ Stroke
- ❑Epilepsy/seizures
- ❑ Multiple Sclerosis
- ❑ Head injury
- ❑Osteoporosis
- ❑ Chronic fatigue syndrome
- ❑ Fibromyalgia
- ❑ Arthritic conditions
- ❑ Bone fracture
- ❑ Sports injuries
- ❑ TMJ/ neck pain
- ❑Emphysema/ chronic bronchitis
- ❑ Thyroid problems
- ❑Headaches/ migraines
- ❑ Diabetes
- ❑ Kidney disease
- ❑ Irritable bowel syndrome
- ❑ Hepatitis
- ❑ Physical or sexual abuse
- ❑Connective tissue disorder
- ❑Hernia
- ❑Autoimmune condition
- ❑ Vision problems
- ❑ Asthma
- ❑ Allergies/ list: _____
- ❑ Other/ describe: _____

Are you currently under the care of any other medical provider for the symptoms bringing you here today or any other condition? YES / NO

What prescription medications and/or supplements are you taking and why? _____
_____

Goals

What are your goals for treatment? _____
_____

What activities, specifically, are difficult or are you unable to perform due to the condition you are seeking treatment for today?

1. _____
2. _____
3. _____