# Pelvic Health Medical Intake Form

| **Patient Name:** | **Preferred Pronouns:** | **Date of Birth:** |
|---|---|---|
| **Referring Physician:** | **Primary Care Physician:** | **Date of Initial Onset:** |
| **Reason for Therapy:** | | |
| **Additional Treatment for Current Condition:** | | |
| **What aggravates your symptoms?** | | |
| **What relieves your symptoms?** | | |
| **What are your goals for physical therapy?** | | |
| **Have you fallen in the last year?** Yes / No **If yes, how many times?** ___ **If yes, any injury?** Yes / No<br>**Do you feel unsteady when standing or walking?** Yes / No **Do you worry about falling?** Yes / No | | |

| **Please circle all that apply from the following list:** | | |
|---|---|---|
| Allergies (specify_____) | Dizziness | Kidney problems |
| Anemia | Epilepsy or seizure disorder | Metal implants |
| Anxiety or panic disorders | Fainting | MRSA |
| Arthritis | Fever or chills | Multiple sclerosis |
| Asthma | Fractures | Nausea or vomiting |
| Blood thinners | Headaches | Osteoporosis |
| Bowel or bladder disorder | Head injury or concussion | Pacemaker |
| Bleeding disorder | Hearing impairment | Parkinson's disease |
| Cancer | Heart disease | Peripheral vascular disease |
| Cough | Hepatitis A or B or C | Respiratory Problems |
| COPD | Hernia | Ringing in ears |
| Congestive heart failure | Blood pressure high or low | Skin abnormalities |
| Deep vein thrombosis | HIV or AIDS | Stroke or TIA |
| Depression | Hypoglycemia | Thyroid problems |
| Diabetes Type 1 or Type 2 | Sensitivity to hot or cold | Tuberculosis |
| List any other medical conditions: | | |

| **Please list any previous abdominal or pelvic surgeries:** | |
|---|---|
| Surgery Type/Reason: | Date of Surgery |
| | |
| | |
| | |
| | |

| Please list any current medications: | | |
|---|---|---|
| Name of Medication: | Dosage: | Frequency: |
| | | |
| | | |
| | | |
| | | |
| | | |

| Please list pregnancy history and circle the following that apply: | | |
|---|---|---|
| Number of pregnancies: | Number of births:<br>Vaginal Cesarean | Please list birth years: |
| Prolonged laboring/pushing | Episiotomy | Forceps/vacuum assist |
| Tearing: Grade 1 or 2 or 3 or 4 | Additional complications: | |

| Please circle any of the following urinary symptoms that apply: | | |
|---|---|---|
| Urinary leakage | Incomplete emptying | Pain with urination |
| Urinary urgency | Straining to urinate | Bleeding with urination |
| Urinary frequency | Weak urine stream | |
| # of times urinating per day_____/per night_____ | | |

| Please circle any of the following bowel symptoms that apply: | | |
|---|---|---|
| Fecal leakage | Gas leakage | Pain with bowel movements |
| Bowel movement urgency | Straining for bowel movement | Bleeding with bowel movements |
| Bowel movement frequency | Constipation | Diarrhea |
| Incomplete bowel emptying | Hemorrhoids | |
| # of bowel movements per day_____/per night_____ | | |

| Please circle any of the following additional pelvic symptoms that apply: | | |
|---|---|---|
| Pelvic pain with penetration | Pelvic pain with orgasm | Painful periods |
| Pelvic numbness/tingling | Difficulty achieving orgasm | Bleeding with urination |
| Difficulty achieving erection | Difficulty maintaining erection | Painful erections |
| Painful ejaculation | Weak ejaculation | Penile/testicular pain |
| Pressure/heaviness in ___vagina/ ___rectum/ ___lower abdomen | | |
| Pelvic organ prolapse ___bladder/ ___rectal/ ___uterine | | |

| Signature of Patient: | Date: |
|---|---|
| Signature of Therapist: | Date: |

**Pelvic Health Consent for Evaluation and Treatment**

I acknowledge and understand that I have been referred for evaluation and treatment of Pelvic Floor Dysfunction. Pelvic Floor Dysfunction may include but is 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 my condition, it may be necessary, initially, and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin conditions, reflexes, muscle tone, length, strength and endurance, scar ability and function of the pelvic floor region. Such evaluation may involve vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but is not limited to, the following: observation, palpation, use of vaginal weight, 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 hereby acknowledge/understand the following:

1. My therapist has explained the purpose, risks, and benefits of this treatment to me.
2. I understand that I can terminate the treatment at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I understand that I may request that a second staff member be present in the room during the treatment, given the sensitive nature of this procedure.
5. I understand that, for therapy to be effective, I must come as scheduled unless unusual circumstances prevent me from attending therapy.
6. I agree to cooperate with and carry out the home program assigned to me, and if I have difficulty with any part of my treatment program, I will discuss it with the therapist.

_____ _____

Patient Name Date

_____ _____

Patient Signature Signature of Parent/Legal Guardian (if applicable)

_____

Staff Member/Witness Signature

**PLEASE NOTE: If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity to lubricant gel/vaginal creams or latex, please inform the therapist prior to the pelvic floor assessment.**

Male | Female

Patient Name:_____ Date: _____

## Pelvic Floor Distress Inventory Questionnaire - Short Form 20

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder or pelvic symptoms and if you do how much they bother you. Answer each question by putting an **X** in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months.**

| | | | **If yes**, how much does it bother you? | | | |
|---|---|---|---|---|---|---|
| | | | **Not at all** | **Somewhat** | **Moderately** | **Quite a bit** |
| 1 | Do you usually experience pressure in the lower abdomen? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 2 | Do you usually experience heaviness or dullness in the lower abdomen? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 3 | Do you usually have a bulge or something falling out that you can see or fell in the vaginal area? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 4 | Do you usually have to push on the vagina or around the rectum to have a complete bowel movement? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 5 | Do you usually experience a feeling of incomplete bladder emptying? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 6 | Do you ever have to push up in the vaginal area with your fingers to start or complete urination? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 7 | Do you feel you need to strain too hard to have a bowel movement? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 8 | Do you feel you have not completely emptied your bowels at the end of a bowel movement? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 9 | Do you usually lose stool beyond your control if your stool is well formed? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |



Kathy V. Jones, MD

Male / Female

Patient Name:_____ Date: _____

| | | | If yes, how much does it bother you? | | | |
|---|---|---|---|---|---|---|
| | | | Not at all | Somewhat | Moderately | Quite a bit |
| 10 | Do you usually lose stool beyond your control if you stool is loose or liquid? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 11 | Do you usually lose gas from the rectum beyond your control? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 12 | Do you usually have pain when you pass your stool? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 13 | Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 14 | Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 15 | D you usually experience frequent urination | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 16 | Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 17 | Do you usually experience urine leakage related to laughing, coughing, or sneezing> | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 18 | Do you usually experience small amounts of urine leakage (that is, drops)? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 19 | Do you usually experience difficulty emptying your bladder? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |
| 20 | Do you usually experience pain of discomfort in the lower abdomen or genital region? | YES ☐ NO ☐ | ☐ | ☐ | ☐ | ☐ |