Back in Motion®
PHYSICAL THERAPY LLC

Pelvic Health Patient Intake Form

Name: _____ **Date:** _____

1. Describe the current problem that brought you here.

_____

_____

2. Are you experiencing pain? ☐ Yes ☐ No
   If yes, please rate your pain on a 0—10 pain scale, 10 being the worst: _____
   Describe the nature of the pain (e.g. constant burning, intermittent ache):

_____

_____

3. Describe previous treatment or exercises:

_____

_____

4. Activities that cause or aggravate your symptoms. Check all that apply.

☐ Sitting greater than ____ minutes
☐ Walking greater than ____ minutes
☐ Standing greater than ____ minutes
☐ Changing positions (e.g. sit to stand)
☐ Light activity (light housework)
☐ Vigorous activity or exercise (e.g. run, weight lift, or jump)
☐ Sexual activity
☐ Other, please list:

☐ With cough, sneeze, or straining
☐ With laughing or yelling
☐ With lifting or bending
☐ With cold weather
☐ With trigger — running water or key in door
☐ With nervousness or anxiety
☐ No activity affects the problem

_____

5. What relieves your symptoms?

_____

_____

6. Rate your feelings as to the severity of this problem from 0-10, with 0 being no problem and 10 being the worst. ____

7. What are your personal goals for therapy?

_____

_____

Mental Health: Current level of stress: ☐ High ☐ Medium ☐ Low
Current psych therapy? ☐ Yes ☐ No

Exercise: ☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5+ days/week
Describe:

_____

_____

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

☐ Shortness of Breath or Chest Pain
☐ Coronary Heart Disease or Angina
☐ Pacemaker or defibrillator
☐ High Blood Pressure
☐ Heart Attack or Surgery
☐ Stroke or TIA
☐ Blood Clot or Emboli
☐ Epilepsy or Seizures
☐ Thyroid Trouble or Goiter
☐ Anemia
☐ Infectious Disease
☐ Diabetes
☐ Cancer
☐ Arthritis or Swollen Joints
☐ Osteoporosis
☐ Gout
☐ Sleeping Difficulties
☐ Emotional or Psychological Problems
☐ Irritable Bowel Syndrome
☐ Hepatitis
☐ HIV or AIDS
☐ STD or STI
☐ Physical or Sexual abuse
☐ Raynaud's (cold hands and feet)
☐ Allergies
☐ Asthma
☐ Other: _____
☐ Emphysema
☐ Pelvic pain
☐ Severe or Frequent Headaches
☐ Vision or Hearing Difficulties
☐ Numbness or Tingling
☐ Dizziness or Fainting Weakness
☐ Weight Loss or Energy Loss
☐ Hernia
☐ Varicose Veins
☐ Do you smoke?
☐ Are you pregnant?
# of weeks: _____

Procedure History

☐ Surgery for your back or spine
☐ Surgery for your brain
☐ Surgery for your female organs
☐ Other, describe:
☐ Surgery for your bladder or prostate
☐ Surgery for your bones or joints
☐ Surgery for your abdominal organs

_____
_____

Females only

☐ Childbirth vaginal deliveries, #: ____
☐ Episiotomy #: ____
☐ C-Section #: ____
☐ Difficult childbirth #: ____
☐ Prolapse or organ falling out
☐ Other, describe:
☐ Vaginal dryness
☐ Painful periods
☐ Menopause – when? ____
☐ Painful vaginal penetration
☐ Pelvic pain

_____

Males only

☐ Prostate disorders
☐ Shy bladder
☐ Pelvic pain
☐ Other, describe:
☐ Erectile dysfunction
☐ Painful ejaculation

_____

Medications

Please list any allergies (e.g. latex, adhesives): _____

Are you currently taking any prescription or non-prescription medications? ☐ Yes ☐ No

☐ Anti-inflammatories ☐ Muscle Relaxers ☐ Pain Medication

List Medications

_____

_____

Bladder, Bowel Habits

☐ Trouble initiating urine stream
☐ Urinary intermittent or slow stream
☐ Trouble emptying bladder
☐ Difficulty stopping the urine stream
☐ Trouble emptying bladder completely
☐ Straining or pushing to empty bladder
☐ Dribbling after urination
☐ Constant urine leakage
☐ Blood in urine
☐ Painful urination
☐ Trouble feeling bladder urge or fullness
☐ Current laxative use
☐ Trouble feeling bowel, urge, fullness
☐ Constipation or straining
☐ Trouble holding back gas or feces
☐ Recurrent bladder infection
☐ Other, describe: _____

1. Frequency of urination: awake hours _____ times per day, sleep hours _____ time per night

2. 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

3. The usual amount of urine passed is: ☐ small ☐ medium ☐ large.

4. Frequency of bowel movements ____ times per day, ____ times per week, or _____

5. 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.

6. If constipation is present describe management techniques:

_____

7. Average fluid intake (one glass is 8 oz or one cup) ____ glasses per day.

8. Rate a feeling of organ “falling out,” prolapse, or pelvic heaviness or pressure:
   ☐ None present
   ☐ ____ Times per month (specify if related to activity or your period)
   ☐ With standing for ____ minutes or ____ hours.
   ☐ With exertion or straining
   ☐ Other: _____

Skip questions if no leakage or incontinence

9a. Bladder leakage — number of episodes
☐ No leakage
☐ ____ Times per day
☐ ____ Times per week
☐ ____ Times per month
☐ Only with physical exertion or cough

9b. On average, how much urine do you leak?
☐ No leakage
☐ Just a few drops
☐ Wets underwear
☐ Wets Outwear
☐ Wets Floor

10a. Bowel leakage – number of episodes
☐ No leakage
☐ ____ Times per day
☐ ____ Times per week
☐ ____ Times per month
☐ Only with exertion or strong urge

10b. How much stool do you lose?
☐ No leakage
☐ Stool staining
☐ Small amount in underwear
☐ Complete emptying

11. What form of protection do you wear? (Please complete only one)
☐ None
☐ Minimal protection (tissue paper, paper towel, panti-shields)
☐ Moderate protection (absorbent product, maxipad)
☐ Maximum protection (specialty product, diaper)
☐ Other: _____

12. On average, how many pad or protection changes are required in 24 hours? ____ # of pads

INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION

During your 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, for females, or rectally, for 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 with you and receive your consent before initiating this exam. You may decline the internal examination and biofeedback assessment for any reason, and your physical therapist will assess and treat the pelvic floor muscles externally if needed. The assessment of the pelvic floor muscles may result in soreness or temporary discomfort. If this occurs, please consult with your physical therapist.

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

By signing this form, you agree and understand that treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat you as outlined here and through your future consent. You may change your consent at any time during the course of treatment by notifying your physical therapist of any changes in your consent.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment. The second person may be a friend, family member, or clinic staff member. Your physical therapist may also request a second person be in the room as a chaperone. If this is the case, you will be notified prior to the pelvic floor muscle evaluation and treatment.

I have read and understand the Informed Consent for Pelvic Floor Muscle Evaluation, and I consent to the evaluation and treatment, unless otherwise noted below.

Signature: _____ Date: _____