therapydia
Physical Therapy • Personal Wellness

Pelvic Health Intake Form

Name: ________________________________ Pronouns: _____________ Date: _______

1) Describe the reason you are seeking help. (What are you avoiding due to pain, discomfort, weakness, fear, leakage, pressure, or urge?)
____
____
____

2) When/how did your problem start:
____
____
____

3) Since your problem started is it: ______ the same, _______ worse, or _____ better?

4) If you have pain, rate your pain using 0-10 scale, with 10 being the worst.
Current Pain ___________ Pain at worst _________ Pain at best ______________

5) What treatments (if any) have you had:
____
____
____

6) What relieves your symptoms?
____
____
____

7) What activities increase/aggravate your symptoms? Check all that apply
- ______Sitting greater than ______ minutes
- ______Standing greater than ______ minutes
- ______Walking greater than ______ minutes
- ______Changing positions (sit to stand, laying to standing)
- ______Light activity/housework
- ______Vigorous activity/exercise (running, weight lifting, jumping)
- ______Sexual activity
- ______Coughing, sneezing, straining
- ______Laughing/yelling
- ______Lifting/bending
- ______Cold Weather
- ______Environmental Triggers (running water, keys in the door)
- ______Nervousness/Anxiety
- ______Other, please specify: ______________________________________
- ______None

Pelvic Health History

1) When was your last pelvic examination ____

2) Is there anything you would like your therapist to know about your gender:
____
____

3) Have you had any pelvic tests run (ultrasound, manometry, urinalysis, etc), if so what/when:
____
____
____

4) Are you sexually active ______ Yes _______ No _____Unable due to current problem
   Pain/problems with sexual activity include:
   ____

5) Do you have a history or pelvic disease or sexually transmitted infections:
____
____

6) Do you have a history of any pelvic surgery (prostatectomy, gender affirmation, prolapse repair, endometriosis, etc):
____
____
____

7) Pregnancy History: ______ N/A
   1) Number of pregnancies: ____
   2) Number of vaginal births: ____
   3) Number of belly (C-section) births: ______
   4) I have not been pregnant, but am attempting pregnancy ____
   5) I am currently pregnant, my due date is: _________

8) Vaginal History: _____N/A
   1) Vaginal Dryness Y/N
   2) Painful Periods Y/N
   3) Menopause - specify when ________________
   4) Pain with penetration ____

9) Penile History: ____ N/A
   1) Erectile dysfunction Y/N
   2) Painful ejaculation Y/N
   3) Prostate disorder ____

10) Prolapse History/Pelvic Heaviness/Pelvic Pressure: _______ N/A
   1) Times per month: _______________
   2) Activities that aggravate symptoms:
      1) _______Standing _______Minutes or ______Hours
      2) ________Exertion or Straining, specify: ______________________________________

Bowel/Bladder Health

1) Have you ever been diagnosed with:
   _______ GERD ______ IBS _____ SIBO ______ Constipation _____ Diarrhea

2) How many times do you urinate during the day: ______________________

3) How many times do you wake to urinate at night: ____________________

4) When you have urge to urinate, how long can you delay prior to going: _________________

5) How often do you have a bowel movement: ____

6) When you have an urge for a bowel movement, how long can you delay prior to going:
   ____

7) Bladder Leakage: _____ N/A
   Frequency: _____Times per day _____ Times per week _____ Times per month

   Amount: ____ A few drops. _____ Wets underwear ___ Wets outerwear ____ Wets Floor

8) Bowel Leakage: ____ N/A
   Frequency: _____Times per day _____ Times per week _____ Times per month

   Amount: __ Stains underwear __ Small amount in underwear ___ Complete Emptying

9) What, if any, protection do you wear for bowel/bladder leakage? (tissue, pads, liners, etc.)
   ____

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Other/describe ____

Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections

Medications

Medications - pills, injection, patch	Start date	Reason for taking

Over the counter -vitamins etc	Start date	Reason for taking