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Health Intake Pelvic Health (GYN)

General Patient Information (Required)

Last Name

First Name

Today's Date MM/DD/YYYY

Address

Cell Phone

Email

Date of Birth MM/DD/YYYY

Marital Status

Occupation

Employer

How many hours/week do you work?

Are you on leave and/or disability?

Emergency Contact Name

Emergency Contact Phone

Primary Care Physician Name/Group

Date of Next Visit MM/DD/YYYY

OB/GYN Name/Group

Date of Next Visit MM/DD/YYYY

How did you hear about us?

If referred by a friend or family member, please provide their name and number below so that I may send a thank you note and/or small gift.

Primary Issue/Concern (Required)

Describe the current problem/issue/concern that brings you into see me?

When did this problem first begin? (i.e. months, years)

Since this problem started, would you say it is:

- ○ Staying the same
- ○ Getting better
- ○ Getting worse
- ○ It varies

If pain is present, rate this pain on a 0-10 scale with 10 being the worst. __/10

For example: Mild pain (1-3/10) likely doesn't interfere with your regular activities, Moderate pain (4-6/10) may interfere, and Severe pain (7-9/10) keeps you from doing your regular activities.

Describe the nature of the pain (i.e. burning, aching, cramping, constant, intermittent, etc.).

Describe any previous treatments, exercises and/or management techniques you have utilized for this issue?

As a result of your issue/concern, what activities cause and/or aggravate your symptoms. Check all that apply.

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Changing Positions (i.e. sit to stand)
- ☐ Light Activity (light housework)
- ☐ Vigorous activity/exercises (running/weight lifting/jumping)
- ☐ Sexual Activity
- ☐ Coughing/Sneezing/Straining
- ☐ Laughing/Yelling
- ☐ Lifting/Bending
- ☐ Cold Weather
- ☐ Triggers (i.e. running water, key in door)
- ☐ Nervousness/Anxiety
- ☐ No activity affects the problem

Please list and/or describe any other activities not listed above.

What relieves your symptoms?

Since the onset of your current symptoms have you had:

- ☐ Fever/Chills
- ☐ Unexplained weight change
- ☐ Dizziness or fainting
- ☐ Changes in bowel or bladder functions
- ☐ Malaise (unexplained tiredness)
- ☐ Unexplained muscle weakness
- ☐ Night pain/sweats
- ☐ Numbness/Tingling
- ☐ None of the above

How has your lifestyle/quality of life been altered/changed because of this problem? Please consider social activities, diet/fluid intake, physical activity, work.

Rate the severity of this problem from 0-10 with 0 being no problem and 10 being the worst. ___/10

What are your treatment goals and activities would you like to be able to do as a result of physical therapy? Anything else you would like your physical therapist to know?

Health History (Required)

When was the date of your last physical exam, either primary care or OB/Gyn?

What tests were performed?

How would you grade your general health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

How would you rate your current level of stress and/or anxiety?

- ○ High
- ○ Medium
- ○ Low

Are you currently seeing a mental health therapist?

- ○ Yes
- ○ No

How often do you exercise per week?

- ○ None
- ○ 1-2 days/week
- ○ 3-4 days/week
- ○ 5+ days/week

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

- ☐ Cancer
- ☐ Stroke
- ☐ Emphysema/Chronic Bronchitis
- ☐ Heart Problems
- ☐ Epilepsy/Seizures
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Allergies-list below
- ☐ Ankle Swelling
- ☐ Blood Clots
- ☐ Head Injury
- ☐ Latex Sensitivity
- ☐ Anemia
- ☐ Osteoporosis
- ☐ Hypothyroid/Hyperthyroid
- ☐ Low Back Pain
- ☐ Chronic Fatigue Syndrome
- ☐ Headaches/Migraines
- ☐ Sacroiliac/Tailbone Pain
- ☐ Fibromyalagia
- ☐ Diabetes
- ☐ Alcoholism/Drug Problem
- ☐ Arthritic Conditions
- ☐ Kidney Diseases
- ☐ Childhood Bladder Problems
- ☐ Stress Fracture
- ☐ Irritable Bowel Syndrome
- ☐ Depression
- ☐ Rheumatoid Arthritis
- ☐ Hepatitis/HIV/AIDS
- ☐ Anorexia/Bulimia
- ☐ Joint Replacement
- ☐ Sexually Transmitted Disease
- ☐ Smoking History
- ☐ Bone Fracture
- ☐ Physical or Sexual Abuse
- ☐ Vision/Eye Problems
- ☐ Sports Injuries
- ☐ Raynaud's (cold hands and feet)
- ☐ Hearing Loss/Problem
- ☐ TMJ/Neck Pain
- ☐ Pelvic Pain
- ☐ None of the above

Please describe further anything listed above.

Have you had any of the following surgeries and/or procedures? Check all that apply.

- ☐ Surgery for back/spine
- ☐ Surgery for your brain
- ☐ Surgery for your female organs
- ☐ Surgery for your bladder
- ☐ Surgery for your bones/joints
- ☐ Surgery for your abdominal
- ☐ None of the above

Please describe further anything listed above.

List ALL medications (pills, injection, patch), vitamins, supplements, etc which you are currently taking, and the reason for taking.

Pelvic History (Required)

Are you currently pregnant?

- ○ Yes
- ○ No
- ○ NA

If pregnant, please give the estimated due date:

Number of Pregnancies

Number of Vaginal Deliveries

Number of Cesarean Deliveries

List Dates of deliveries (vaginal or cesarean)

Did you have any perineal tearing, episiotomies and/or difficulty with childbirth? Please explain:

Menstrual cycle: regular? painful? cycle length?

Have you been through menopause? If so, when? And, what were your symptoms?

History of chronic urinary tract or bladder infections?

- ○ Yes
- ○ No

History of yeast infections?

- ○ Yes
- ○ No

Do you use any vaginal creams or prescribed vaginal medications? If yes, please list:

Do you experience vaginal dryness? If so, do you use lubrication? If yes, please list:

Do you experience pain with penetration? If yes, please explain:

Please rate a feeling of organ "falling out" sensation/prolapse and/or pelvic heaviness/pressure.

- ○ None present
- ○ Multiple times per month
- ○ With standing for long periods of time
- ○ With exertion and/or straining

Bladder Health (If Applicable)

Do you have any concerns about your bladder health/function? If "no", you can skip the rest of this section.

- ○ Yes
- ○ No

What are your main concerns about your bladder health/function?

Please check any of the boxes that apply:

- ☐ I leak when I cough, sneeze, or laugh
- ☐ I leak when I jump, run, or lift something
- ☐ If I feel the urge, I do not always make it to the toilet in time
- ☐ I do not completely empty my bladder
- ☐ I have to push or strain to empty my bladder
- ☐ I dribble after I urinate
- ☐ I have trouble initiating urine stream
- ☐ I cannot stop the flow of urine once started
- ☐ I have pain or burining when I urinate
- ☐ I have pain when I wipe
- ☐ I go "just in case"
- ☐ If I hear water running, I might leak

Please describe any other bladder issues you may have:

How many times do you urinate during the day?

- ☐ 2-4 times
- ☐ 4-8 times
- ☐ 8-12 times
- ☐ more than 12 times

How many times do you urinate at night?

- ☐ No times
- ☐ 1-2 times
- ☐ 3-4 times
- ☐ more than 4 times

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?

- ○ A few minutes
- ○ An hour
- ○ Not at all

What is your normal amount of urine passed each time you go?

- ○ Small
- ○ Medium
- ○ Large

What is your average fluid intake per day? (One glass is 8oz or one cup)

- ☐ 1-2 glasses
- ☐ 2-4 glasses
- ☐ 4-8 glasses
- ☐ More than 8 glasses

Besides water, what you drink each day, and about how many ounces?

If you experience leaking of urine, how often do you leak?

- ○ At least once a day
- ○ At least once a week
- ○ At least once a month
- ○ Only with physical exertion/cough

On average, during a leaking episode, how much urine do you leak?

- ○ Just a few drops
- ○ Wets underwear
- ○ Wets outerwear
- ○ Wets the floor

What form of protection for urine leakage do you wear?

- ○ None
- ○ Minimal Protection (tissue paper/pantishield)
- ○ Moderate Protection (Maxipad)
- ○ Maximum Protection (Speciality product/diaper)

Bowel Health (If Applicable)

Do you have any concerns about your bowel health/function? If "no", you can skip the rest of this section.

- ○ Yes
- ○ No

What are your main concerns about your bowel health/function?

How many times do you have a bowel movement during the DAY?

- ☐ 0-1 times
- ☐ 2-4 times
- ☐ 5-7 times
- ☐ more than 7 times

How many times do you have a bowel movement during a WEEK?

- ☐ 0-1 times
- ☐ 2-4 times
- ☐ 5-7 times
- ☐ more than 7 times

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?

- ○ Indefinitely
- ○ Only for 15 minutes or less
- ○ For maybe 30 minutes or more
- ○ I cannot delay

If you experience leaking of stool, how often do you leak?

- ○ At least once a day
- ○ At least once a week
- ○ At least once a month
- ○ Only with exertion/strong urge

On average, during a leaking episode, how much stool do you lose?

- ◯ Stool staining
- ◯ Small amount in underwear
- ◯ Complete emptying

What form of protection for bowel leakage do you wear?

- ◯ None
- ◯ Minimal Protection (tissue paper/pantishield)
- ◯ Moderate Protection (maxipad)
- ◯ Maximal Protection (speciality product/diaper)

If constipation is present, describe management techniques.

Do you have to do anything special to help evacuate your bowels? Please explain:

Do you push or strain to empty your bowels?

- ◯ Yes
- ◯ No

Do you use laxatives?

- ◯ Yes
- ◯ No
- ◯ On occasion