You have been referred to physical therapy for evaluation and treatment of a pelvic floor condition. To better understand your condition the evaluation will include an assessment of your pelvic floor muscles.

This MAY include:

1. Observation of your pelvic floor through ultrasound at the abdominal wall
2. Internal evaluation of your pelvic floor muscles for tenderness and strength
3. External evaluation of abdominal wall and hip muscles for tenderness and strength

Please know that your comfort is important. If at any point you are not comfortable with the evaluation or treatment, please let me know. I will work with you to meet your needs.

If you feel more comfortable having another person in the room, please invite someone to accompany you to your physical therapy appointment.

This questionnaire is not gendered. Fill out whatever is applicable/what you would like me to know.

True North
Pelvic PT

**NAME:** **DOB:** **Pronouns:**

**Please fill in the following. Either electronically or print it and fill it out with a pen.**

**Share it with me at your visit. If inconvenient, we can review this on the day of your visit.**

**The reason for your appointment:**

**When did this begin?**

**Is it getting**: BETTER? WORSE? STAYING THE SAME?

**Goal for physical therapy**:

**Number of pregnancies:** **Number of vaginal deliveries:**

**Birth weight of baby/babies:** **Number of cesarean deliveries:**

**Birth related injuries*:**

**Abdominal wall surgeries*:**

**Pelvic surgeries*:**

**** include details at the end of the form if needed***

Did you have any issues healing after delivery? Y N

Is infertility an issue for you? Y N

Are you currently pregnant? Y N

Do you have a history of sexual trauma? Y N

Are you having regular menstrual cycles/periods? Y N

Do you have an IUD? Y N

Do you have frequent urinary tract infections? Y N

## Do you have pain with:

**Intercourse?** Y N Not relevant

**Level 1**: painful, but able to have penetration at the same frequency

**Level 2**: painful and limits frequency

**Level 3:** painful and prevents penetration

**Pelvic exams?** Y N

**Tampon insertion**? Y N

**Orgasm?** Y N

**Pressure on the genitals**? Y N

**Pressure on the abdominal wall**? Y N

## Tests Performed:

| | | |
|---|---|---|
| Urodynamic Tests | Y | N |
| Cystoscopy | Y | N |
| Urine culture Test | Y | N |
| Bowel function Tests | Y | N |
| Colonoscopy | Y | N |

## Do you lose urine when you:

| | | | | | |
|---|---|---|---|---|---|
| Cough/sneeze/Laugh/Lift? | Y | N | Run/Exercise/dance/jump? | Y | N |
| Are on your way to the bathroom? | Y | N | Have a strong urge to urinate? | Y | N |
| Hear running water? | Y | N | Have a full bladder? | Y | N |

## Do you have:

Burning/pain with urination? Y N

| | | | | |
|---|---|---|---|---|
| Difficulty starting a stream of urine? | Y | N | | |
| To strain to empty your bladder? | Y | N | | |
| A feeling that you cannot empty fully? | Y | N | | |
| A feeling of pelvic heaviness/falling out? | Y | N | | |
| Pain with a full bladder? | Y | N | | |
| Urgency with urination? | Y | N | | |
| Use liners or pads for leaking urine? | Y | N | | |
| Urinate more than 7 times a day? | Y | N | **How often?** | |
| Get up to urinate after falling asleep? | Y | N | **How often?** | |

How often do you have bowel movements?

**Most common stool consistency/ or combination of these:**
**Liquid Soft Firm Pellets Other**

## Do you:

| | | |
|---|---|---|
| Strain to have a bowel movement? | Y | N |
| Include fiber in your diet? | Y | N |
| Take laxatives regularly? | Y | N |
| Have pain with a bowel movement? | Y | N |
| Have a strong urge to move your bowels? | Y | N |
| Have a history of constipation? | Y | N |
| Have diarrhea often? | Y | N |
| Ignore urges for a bowel movement? | Y | N |
| Not empty when passing stool? | Y | N |
| Press around the anus to help pass stool? | Y | N |

**Fluid Intake (one glass is 8 oz or one cup) How many glasses? What are the beverages?**

| | | |
|---|---|---|
| | # Glasses per day. What? | |
| | # Of caffeinated glasses per day. What? | |
| | # of alcoholic glasses per day. | |

**How would you describe your diet? Any food issues/allergies?**

**Is there anything else that you would like me to know?**

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Thank you!