Patient History

Name_____ **DOB**_____ **Date**_____

1. Describe the current problem that brought you here:_____

_____

2. When did your problem first begin?_____

3. Was your first episode of the problem related to a specific incident? **Yes / No**
Please describe and specify date_____

_____

4. Since that time is it staying the *(circle one)* **SAME GETTING WORSE GETTING BETTER**
Why or how?_____

5. Please rate present/current pain. *(0 = no pain, 10 = Worst pain imaginable)*

0 1 2 3 4 5 6 7 8 9 10

6. Describe the nature of the pain (i.e., constant burning, intermittent ache, etc.)_____

_____

7. Describe previous treatment/exercises _____

_____

8. Activities/events that cause or aggravate your symptoms. *(check/circle all that apply)*

___ Sitting greater than _____ minutes
___ Walking greater than _____ minutes
___ Standing greater than _____ minutes
___ Changing positions (i.e. sit to stand)
___ Light activity (i.e. light housework)
___ Vigorous activity/exercise (i.e. run/lift/jump)
___ Sexual activity
___ Other, please list _____

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers
___ With nervousness/anxiety
___ No activity affects the problem

Name_____ **Date**_____

9. What relieves your symptoms? _____

_____

10. How has your lifestyle/quality of life been altered/changed because of this problem?

a. Social activities (exclude physical activity), specify _____

_____

b. Diet/fluid intake, specify _____

c. Physical activity, specify _____

d. Work, specify _____

e. Other, specify _____

11. Rate the severity of this problem *(0 = no problem, 10 = Worst imaginable)*

0 1 2 3 4 5 6 7 8 9 10

12. What are your treatment goals/concerns? _____

_____

_____

13. Since the onset of your current symptoms have you had:

Yes / No	Fever/Chills	**Yes / No**	Malaise (unexplained tiredness)
Yes / No	Unexplained weight changes	**Yes / No**	Unexplained muscle weakness
Yes / No	Dizziness or fainting	**Yes / No**	Night pain/sweats
Yes / No	Change in bowel/bladder function	**Yes / No**	Numbness/Tingling

Yes / No Other, describe _____

14. Surgical/Procedure History

Yes / No	Surgery for your back/spine	**Yes / No**	Surgery for your bladder/prostate
Yes / No	Surgery for your brain	**Yes / No**	Surgery for your bones/joints
Yes / No	Surgery for your female organs	**Yes / No**	Surgery for your abdominal organs

Other, describe _____

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Name_____ **Date**_____

15. Have you ever had any of the following conditions/diagnoses? *(circle all that apply)*

Ankle Swelling	Arthritic Conditions	Irritable Bowel Syndrome
Low Back Pain	Stress Fracture	Sexually Transmitted Disease
Sacroiliac/Tailbone Pain	Acid Reflux	Physical or Sexual Abuse
Childhood Bladder Problems	Joint Replacement	Raynaud's (cold hands/feet)
Anorexia/Bulimia	Bone Fracture	Pelvic Pain
Multiple Sclerosis	TMJ/Neck Pain	Kidney Disease
Head Injury	Emphysema/Chronic Bronchitis	Fibromyalgia
Chronic Fatigue Problem	Asthma	Latex Sensitivity
Cancer	Heart Problems	High Blood Pressure
Anemia	Alcoholism/Drug Problems	Depression
Anxiety	Smoking History	Vision/Eye Problems
Hearing Loss/Problems	Stroke	Epilepsy/Seizures
Osteoporosis	Allergies	Hypothyroid/Hyperthyroid
Headaches	Diabetes	Hepatitis/Liver Problems
Respiratory/Breathing	Gastrointestinal	Blood Clots
Gout	Autoimmune	Sports Injury

Other, describe _____

_____

16. OB/GYN History *(females only)*

Yes / No Pregnancies #_____

Yes / No Deliveries #_____

Type of Delivery: Vaginal # _____ C-Section # _____

Yes / No Difficult Childbirth # _____

Yes / No Prolapse or organ falling out

Yes / No Other, describe _____

Yes / No Vaginal dryness

Yes / No Painful periods

Yes / No Menopause, when? _____

Yes / No Painful vaginal penetration

Yes / No Pelvic/genital pain

17. History *(males only)*

Yes / No Prostate disorders

Yes / No Shy bladder

Yes / No Pelvic/genital pain location _____

Yes / No Other, describe _____

Yes / No Erectile dysfunction

Yes / No Painful ejaculation

18. Medications *(pills, injections, patch, etc.)* Include name, start date, and reason for taking.

_____

_____

_____

_____

_____

_____

_____

19. Over the counter, Vitamins, etc. Include name, start date, and reason for taking.

_____

_____

_____

_____

20. Allergies, including reactions.

_____

_____

_____

21. General Health *(circle one)*

Excellent **Good** **Average** **Fair** **Poor**

22. Activity/Exercise *(circle one)*

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

Describe _____

23. Mental Health: Current levels of stress **___ High ___ Medium ___ Low**

Current psych therapy? **Yes / No**

Date of last physical exam _____ Tests performed _____

_____

_____

_____

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Name_____ **Date**_____

Pelvic Symptom Questionnaire

Bladder/Bowel Habits/Symptoms

Yes / No Trouble initiating urine stream
Yes / No Urinary intermittent/slow stream
Yes / No Strain or push to empty bladder
Yes / No Trouble emptying bladder completely
Yes / No Difficulty stopping the urine stream
Yes / No Blood in the urine
Yes / No Dribbling after urination
Yes / No Seepage/loss of bowel movement w/o awareness
Yes / No Trouble holding back gas/feces
Yes / No Need to support/touch to complete bowel movement
Yes / No Constipation/straining _____% of the time

Yes / No Constant urine leakage
Yes / No Trouble feeling bladder urge/fullness
Yes / No Recurrent bladder infections
Yes / No Painful urination
Yes / No Blood in stool/feces
Yes / No Painful bowel movements
Yes / No Trouble feeling bowel urge/fullness
Yes / No Trouble controlling bowel urge
Yes / No Trouble emptying bowel completely
Yes / No Staining of underwear after bowel movement
Yes / No Current laxative use _____

Yes / No Other, describe _____

1. Frequency of urination: while awake _____ times per day, during sleep waking _____ times 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 or _____ times per week.
5. The bowel movements typically are: watery ___ loose ___ formed ___ pellets ___ other ___
6. 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
7. If constipation is present, describe management techniques _____ _____
8. Average fluid intake *(one glass is 8oz or 1cup)* _____ glasses per day. Of this total, how many are caffeinated? _____ glasses per day.
9. Rate the feeling of organ "falling out"/prolapse or pelvic heaviness/pressure:

None Present	____Times per month (specify if related to menstrual cycle)	With standing for ____ minutes or ____ hours	With exertion or straining	Other_____ _____

Bladder Leakage – number of episodes	Bowel leakage – number of episodes
No Leakage	No Leakage
___ Times per day	___ Times per day
___ Times per week	___ Times per week
___ Times per month	___ Times per month
Only with physical exertion/cough	Only with exertion/strong urge
On average, how much urine do you leak?	How much stool do you lose?
No Leakage	No Leakage
Just a few drops	Stool staining
Wets underwear	Small amount in underwear
Wets outerwear	Complete emptying
Wets floor	Other _____

10. What form of protection do you wear? (Absorbent products, Pads, Diapers, etc.)_____

On average, how many protection changes are required in 24 hours? _____

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INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION

During the 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 (females) or rectally (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 and receive your consent BEFORE initiating the exam.

You can absolutely say NO, and your physical therapist can assess and treat the pelvic floor muscles externally (from the outside) if needed. The assessment of the pelvic floor muscles may result in soreness or discomfort temporarily. If this occurs, please discuss your symptoms with your physical therapist.

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

By signing this form, you agree and understand the treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat as discussed. You are always free to change your mind at any time during your course of treatment, and you are encouraged to notify your physical therapist of any changes of your preferences.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment (as described above). The second person could be a friend, family member, or clinic staff member. Please indicate your preference with your initials:

_____ **YES** I want a second person present during the pelvic floor muscle evaluation and treatment.

_____ **NO** I do not want a second person during the pelvic floor muscle evaluation and treatment.

CONSENT

I have read and understand the INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION, and I consent to the evaluation and treatment, unless other noted below.

Patient Name *(printed)* _____

Patient Signature _____ Date _____

Please list any exceptions to consent – if none, write none.

_____

_____

_____