

Pelvic Floor Medical Intake Form

Name: _____ Age: _____ Date: _____

What is the primary issue / concern that brought you here? _____

When did your symptoms first begin (date)? Was it related to a specific incident? _____

Describe any previous treatment you have had (medical, diagnostics, therapy): _____

If pain is present, rate pain on a 0-10 scale (10 is worst) and describe: _____

What activities cause or aggravate your symptoms? _____

What relieves your symptoms? _____

What activities would you like to return to doing that you are prevented from doing now?

GENERAL HEALTH

Date of last physical exam: _____

Do you engage in regular exercise? If yes, what type and how often? _____

How is your mental health? _____

Does your diet consist of whole grains, fruits and vegetables? _____

How much water do you drink each day? _____

How much caffeine do you drink each day? _____

How much fiber is in your diet? _____

Do you have any of the following symptoms? (Please circle all that apply)

Fever/Chills	Unexplained weight change	Unexplained muscle weakness
Dizziness/Fainting	Night pain/sweats	Change in bowel/bladder function
Malaise	Numbness/Tingling	Other: _____

Have you ever had any of the following conditions or diagnoses? (Please circle all that apply)

Cancer	Epilepsy / Seizures	Physical or sexual abuse
Heart problems	Fibromyalgia	Blood clots
Ankle swelling	Arthritis	Varicose veins
Anemia	Broken bones (fractures)	Bowel or bladder problems
Depression or Anxiety	Breathing trouble	Pacemaker or metal implants
Anorexia or Bulimia	Diabetes	Neurological problems
Stroke / TIA	Sexually transmitted disease	Other: _____

List medications and supplements (Include start date and reason for taking):

Describe surgical / procedure history?

Obstetrics / Gynecological History

Are you currently pregnant? If so, what is your estimated due date? _____
Number of pregnancies _____
Vaginal and/or Cesarean deliveries _____
List dates of deliveries _____
Episiotomy or Perineal Tearing? _____
Difficult childbirth? _____
Prolapse _____
Vaginal dryness _____
Painful periods? _____

Menstrual cycle: regular? Painful? Cycle length? _____
Menopause (when was your last period?) _____
Are you currently sexually active or have you been in the past? _____
History of difficulty with vaginal exams? _____
Chronic urinary tract or bladder infections? _____
History of yeast infections? _____
Painful vaginal penetration? _____
Do you use vaginal cream or lubricant? _____

Bladder / Bowel Habits or Problems (Please circle all that apply)

Trouble initiating / difficulty stopping urine stream
Intermittent/slow urine stream
Dribbling after urination
Trouble emptying or straining to empty bladder
Constant urine leakage
Blood in Urine

Painful urination
Trouble feeling bladder or bowel urge/fullness
Current Laxative use
Constipation/straining
Trouble holding back gas/feces
Recurrent bladder infections

Frequency of Urination: times per day _____ per night _____ Amount passed is Small / Medium / Large
Frequency of Bowel Movements: times per day _____ per night _____

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

What are your main concerns about your bladder and bowel health / function? _____

If experiencing incontinence:

Bladder Leakage (if yes, how frequently): _____

Bowel Leakage (if yes, how frequently): _____

What form of protection do you wear (if any)? _____

Do you ever feel as if an organ is falling out, or have increased pelvic heaviness? If yes, please describe: _____

Do you have low back pain/sciatica or abdominal or pelvic pain (if yes, please describe): _____

Do you have any other questions or concerns that you would like to discuss with your practitioner? _____

How did you hear about our practice? _____

Pelvic Floor Examination Consent (required)

Have you had a vaginal examination in the past? If so, did you have any difficulty? _____

I give my consent to the physical therapist to do a vaginal examination for the purpose of evaluating my condition and providing therapeutic intervention. Initials _____

I understand I can terminate the examination and treatment at any time. Initials _____

I understand that I am responsible for immediately telling the examiner if I am having discomfort or unusual symptoms during the examination and treatment. Initials _____