

Pelvic Health Patient History

Name _____ Age _____ Date _____

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

2. When did your problem first begin? _____ months ago or _____ years ago.

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 same _____ getting worse _____ getting better _____
Why or how? _____

5. If pain is present rate pain on a 0-10 scale 10 being the worst _____. Describe the nature of the pain (i.e. constant burning, intermittent ache) _____

6. Describe any previous treatment/exercises for this condition _____

7. Activities/events that cause or aggravate your symptoms. Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Sitting greater than _____ minutes | <input type="checkbox"/> With cough/sneeze/straining |
| <input type="checkbox"/> Walking greater than _____ minutes | <input type="checkbox"/> With laughing/yelling |
| <input type="checkbox"/> Standing greater than _____ minutes | <input type="checkbox"/> With lifting/bending |
| <input type="checkbox"/> Changing positions (i.e. - sit to stand) | <input type="checkbox"/> With cold weather |
| <input type="checkbox"/> Light activity (light housework) | <input type="checkbox"/> With triggers -running water/key in door |
| <input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump) | <input type="checkbox"/> With nervousness/anxiety |
| <input type="checkbox"/> Sexual activity | <input type="checkbox"/> No activity affects the problem |
| <input type="checkbox"/> Other, please list _____ | |

8. What relieves your symptoms? _____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify _____
Diet/Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

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

11. What are your treatment goals/concerns? _____

Since the onset of your current symptoms have you had:

- | | | | |
|-----|--------------------------------------|-----|---------------------------------|
| Y/N | Fever/Chills | Y/N | Malaise (Unexplained tiredness) |
| Y/N | Unexplained weight change | Y/N | Unexplained muscle weakness |
| Y/N | Dizziness or fainting | Y/N | Night pain/sweats |
| Y/N | Change in bowel or bladder functions | Y/N | Numbness / Tingling |
| Y/N | Other /describe _____ | | |



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Health History: Date of Last Pelvic Exam _____ Tests performed _____

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week _____ On disability or leave? _____ Activity Restrictions? _____

Mental Health: Current level of stress High ___ Med ___ Low ___ Current psych therapy? Y/N

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week

Describe _____

Have you ever had any of the following conditions or diagnoses? circle all that apply /describe

- | | | |
|----------------------------|--------------------------|---------------------------------|
| Cancer | Stroke | Emphysema/chronic bronchitis |
| Heart problems | Epilepsy/seizures | Asthma |
| High Blood Pressure | Multiple sclerosis | Allergies-list below |
| Ankle swelling | Head Injury | Latex sensitivity |
| Anemia | Osteoporosis | Hypothyroid/ Hyperthyroid |
| Low back pain | Chronic Fatigue Syndrome | Headaches |
| Sacroiliac/Tailbone pain | Fibromyalgia | Diabetes |
| Alcoholism/Drug problem | Arthritic conditions | Kidney disease |
| 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/problems | TMJ/ neck pain | Pelvic pain |

Other/Describe _____

Surgical /Procedure History

- | | | | |
|-----|--------------------------------|-----|-----------------------------------|
| Y/N | Surgery for your back/spine | Y/N | Surgery for your bladder/prostate |
| Y/N | Surgery for your brain | Y/N | Surgery for your bones/joints |
| Y/N | Surgery for your female organs | Y/N | Surgery for your abdominal organs |

Other/describe _____

Ob/Gyn History (females only)

- | | | | |
|-----|---------------------------------------|-----|-----------------------------|
| Y/N | Childbirth vaginal deliveries # _____ | Y/N | Vaginal dryness |
| Y/N | Episiotomy # _____ | Y/N | Painful periods |
| Y/N | C-Section # _____ | Y/N | Menopause - when? _____ |
| Y/N | Difficult childbirth # _____ | Y/N | Painful vaginal penetration |
| Y/N | Prolapse or organ falling out | Y/N | Pelvic pain |

Y/N Other /describe _____

Males only

- | | | | |
|-----|--------------------|-----|----------------------|
| Y/N | Prostate disorders | Y/N | Erectile dysfunction |
| Y/N | Shy bladder | Y/N | Painful ejaculation |

Y/N Other /describe _____

<u>Medications/Vitamins - pills, injection, patch</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Bladder / Bowel Habits / Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine
Y/N	Urinary intermittent /slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections
Y/N	Other/describe _____		

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____ 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, ____ times per week, or ____.
5. 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.
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz. or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated? _____ glasses per day.
8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
 None present
 Times per month (specify if related to activity or your period)
 With standing for _____ minutes or _____ hours.
 With exertion or straining
 Other _____

Skip questions if no leakage/incontinence

- | | |
|--|---|
| 9a. Bladder leakage - number of episodes | 9b. Bowel leakage - number of episodes |
| <input type="checkbox"/> No leakage | <input type="checkbox"/> No leakage |
| <input type="checkbox"/> Times per day | <input type="checkbox"/> Times per day |
| <input type="checkbox"/> Times per week | <input type="checkbox"/> Times per week |
| <input type="checkbox"/> Times per month | <input type="checkbox"/> Times per month |
| <input type="checkbox"/> Only with physical exertion/cough | <input type="checkbox"/> Only with exertion/strong urge |
-
- | | |
|--|--|
| 10a. On average, how much urine do you leak? | 10b. How much stool do you lose? |
| <input type="checkbox"/> No leakage | <input type="checkbox"/> No leakage |
| <input type="checkbox"/> Just a few drops | <input type="checkbox"/> Stool staining |
| <input type="checkbox"/> Wets underwear | <input type="checkbox"/> Small amount in underwear |
| <input type="checkbox"/> Wets outerwear | <input type="checkbox"/> Complete emptying |
| <input type="checkbox"/> Wets the floor | |

11. What form of protection do you wear? (Please complete only one)
 None
 Minimal protection (Tissue paper/paper towel/pantishields)
 Moderate protection (absorbent product, maxipad)
 Maximum protection (Specialty product/diaper)
 Other _____

On average, how many pad/protection changes are required in 24 hours? ____ # of pads



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PELVIC FLOOR INFORMED CONSENT FOR EVALUATION AND TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

Potential benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Cooperation with treatment:

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants of Primetime Physical Therapy, LLC.

Date _____

Patient Name: _____
(Please Print)

Patient Signature

Signature of Parent or Guardian (If applicable)

Witness Signature