Patient History

Name _____ Age _____ Date _____

1. **Describe the 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/injury? Yes/No**

   Please describe and specify date:
   _____
   _____

4. **Since that time/injury is it: _____ same _____ getting worse _____getting better**
5. **If pain is present, describe pain (ie. constant, burning, intermittent ache): _____**
6. **Describe any previous treatments/exercises:**

   _____

   _____

7. **Check activities that may aggravate your symptoms (any/all that apply)**

_____ Sitting greater than ___ minutes

_____ Walking greater than ___ minutes

_____ Standing greater than ___ minutes

_____ Changing positions (ie. sit to stand)

_____ Light activity (ie. housework)

_____ Vigorous activity (ie. running, jumping, weightlifting)

_____ with sexual activity

_____ with cough/sneeze

_____ with laughing/yelling

_____ with lifting/bending

_____ with cold weather

___ with triggers (ie. running water or key in door)

___ with nervousness/anxiety

___ No activity affects this problem

_____ Other: _____

8. **What relieves your symptoms?**

_____

9. **What are your treatment goals/concerns?**

_____

Health History:

Date of last gynecology exam: _____ Tests performed: _____

_____

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

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

Cancer
Heart Problems
High Blood Pressure
Ankle Swelling
Anemia
Low Back Pain
SI joint/Tailbone pain
Childhood Bladder Problems
Depression
Anorexia/Bulimia
Smoking History
Stroke
Multiple Sclerosis
Osteoporosis
Fibromyalgia
Rheumatoid Arthritis
Allergies (list below)
Hypothyroidism/Hyperthyroidism
Headaches
Irritable Bowel Syndrome
Sexually Transmitted Disease
Physical or Sexual Abuse
Pelvic Pain
Other/Describe: _____

Surgical/Procedure History: Please list and describe procedures to the back/spine, brain, female organs, bladder/prostate, bones/joints, and/or abdominal organs:

_____
_____

OB/GYN History:

Y/N Childbirth vaginal deliveries #_____

Y/N Episiotomy # _____

Y/N C-Section # _____

Y/N Difficult Childbirth # _____

Y/N Prolapse or organ falling out

Y/N Vaginal dryness

Y/N Painful periods

Y/N Menopause – when? _____

Y/N Painful vaginal penetration

Y/N Pelvic Pain

Medications:

_____

_____

Bowel/Bladder Habits:

Y/N Trouble initiating stream

Y/N Urinary intermittent/slow stream

Y/N Trouble emptying bladder completely

Y/N Difficulty stopping the urine stream

Y/N Dribbling after urination

Y/N Constant urine leakage

Y/N Blood in the urine

Y/N Painful urination

Y/N Trouble feeling bladder urge/fullness

Y/N Current laxative use

Y/N Trouble feeling bowel urge/fullness

Y/N Constipation/Straining

Y/N Trouble holding back gas/feces

Y/N Recurrent bladder infection

1. **Frequency of urination: awake hours = _____ times per day, sleep hours = _____ times per night**
2. **The usual amount of urine passed is: _____ small _____ medium _____ large**
3. **Frequency of bowel movements _____ times per day, _____ times per week, or describe _____**
4. **Average fluid intake for the day? (include water and other drinks)**
   _____
5. **Describe the feeling if you have "falling out" feeling of your organs/prolapse/or pelvic heaviness. Specify whether it is occasionally, with prolonged standing, activity, etc.)**
   _____
   _____
6. **If you are having incontinence/leakage, how many times a day or week do you leak, or is it only with physical exertion/cough?**

_____

_____

7. **If you have leakage, how much do you leak on average? (ie. a few drops, wets underwear, wets outerwear, etc.)**

_____

_____

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT'

I 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.

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.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I have the option of having a second person present in the room during the procedure and _____ choose _____ refuse this option.

Date: _____

Patient Name: _____

Patient Signature: _____

Signature of Parent or Guardian (if applicable): _____

Witness Signature: _____