

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

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 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

Medications:

Bowel/Bladder Habits:

Y/N Trouble initiating stream

Y/N Painful urination

Y/N Urinary intermittent/slow stream

Y/N Trouble feeling bladder
urge/fullness

Y/N Trouble emptying bladder
completely

Y/N Current laxative use

Y/N Difficulty stopping the urine stream

Y/N Trouble feeling bowel urge/fullness

Y/N Dribbling after urination

Y/N Constipation/Straining

Y/N Constant urine leakage

Y/N Trouble holding back gas/feces

Y/N Blood in the urine

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: _____