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Pelvic Floor Physical Therapy for Women

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Patient History

Name _____ **DOB** _____ **Age**_____ **Date** _____

Marital Status_____ **Referring Doctor/Practitioner** _____

Address _____

Phone _____ **Email** _____

Emergency Contact Name _____ **Phone** _____

Relationship_____

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 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 previous treatment/exercises. _____

_____

7. What activities/events cause or aggravate your symptoms? Check all that apply.

____ Sitting greater than _____ minutes
____ Walking greater than _____ minutes
____ Standing greater than _____ minutes
____ Changing positions (i.e. sit to stand)
____ Vigorous activity/exercise (running, jumping)
____ Sexual activity
____ Other, please list _____

____ With coughing/sneezing/straining
____ With laughing/yelling
____ With cold weather
____ With triggers (i.e. key in door)
____ With nervousness/anxiety
____ No activity affects the problem

8. What relieves your symptoms? _____

_____

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

Social activities (excluding physical activities), specify _____

_____

Diet/fluid intake, specify _____

Physical activity, specify _____

Work, specify _____

Other _____

10. Rate the severity of this problem from 0-10, 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/fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness/tingling

Y/N Other _____

Date of last physical exam _____ Tests performed _____

_____

General health: Excellent Good Average Fair Poor

Occupation _____ Hours/week _____

On disability or leave? _____ Activity restrictions? _____

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

Describe _____

Current level of stress: High Medium Low Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply.

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High blood pressure	Multiple sclerosis	Allergies (please list below)
Ankle swelling	Head injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/hyperthyroid
Lower 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	Acid reflux/belching	Hepatitis
Anorexia/bulimia	Joint replacement	Sexually transmitted disease
History of smoking	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 _____

Surgical/procedure History

Y/N	Back/spinal surgery	Y/N	Bladder/prostate surgery
Y/N	Brain surgery	Y/N	Surgery on bones/joints
Y/N	Surgery on female organs	Y/N	Surgery on abdominal organs

Other _____

OB/GYN History

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

Other _____

Current medications (pills, injections, patches) Start date Reason for taking

_____

_____

_____

Over the counter (vitamins, etc) Start date Reason for taking

_____

_____

_____

Pelvic Symptom Questionnaire

Y/N	Trouble initiating urine stream	Y/N	Blood in stool/feces
Y/N	Urinary intermittent/slow stream	Y/N	Painful bowel movements (BM)
Y/N	Strain or push to empty bladder	Y/N	Trouble feeling bowel urge/fullness
Y/N	Difficulty stopping urine stream	Y/N	Seepage/loss of BM without awareness
Y/N	Trouble emptying bladder completely	Y/N	Trouble controlling bowel urge
Y/N	Blood in urine	Y/N	Trouble holding back gas/feces
Y/N	Dribbling after urination	Y/N	Trouble emptying bowel completely
Y/N	Constant urine leakage	Y/N	Need to support/touch to complete BM
Y/N	Trouble feeling bladder urge/fullness	Y/N	Staining of underwear after BM
Y/N	Recurrent bladder infections	Y/N	Constipation/straining ___% of the time
Y/N	Painful urination	Y/N	Current laxative use, type _____

Other _____

Describe typical position for emptying bladder or bowel: _____

_____

1. Frequency of urination: awake hours _____ times/day, sleep hours _____ times/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/day, _____ times/week, or _____
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 = 8 oz/1 cup): _____ glasses/day

   Of this total, how many glasses are caffeinated? _____ glasses/day
9. Rate a feeling of organ "falling out"/prolapse/pelvic heaviness or pressure:

___ None present

___ Times/month (related to menstrual period? Y/N)

___ With standing for _____ minutes or _____ hours

___ With exertion or straining

Other _____

10. Bladder leakage, number of episodes:

___ No leakage

___ Times/day

___ Times/week

___ Times/month

___ Only with physical exertion/cough

11. Bowel leakage, number of episodes:

___ No leakage

___ Times/day

___ Times/week

___ Times/month

___ Only with exertion/strong urge

12. On average, how much urine do you leak?

___ No leakage

___ Just a few drops

___ Wets underwear

___ Wets outerwear

___ Wets the floor

13. How much stool do you lose?

___ No leakage

___ Stool staining

___ Small amount in underwear

___ Complete emptying

Other _____

14. What form of protection do you wear?

___ None

___ Minimal protection (tissues, paper towels, panti-shields)

___ Moderate protection (absorbent produce, maxi pad)

___ Maximum protection (specialty product/diaper)

Other _____

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