Patient Information

Medical History

Do you now have or have you ever had any of the following conditions?

	Now	Past		Now	Past
Asthmas/Bronchitis/Emphysema			Cancer		
Shortness of Breath/Chest Pain			Arthritis		
Heart Disease/Angina			Stroke/TIA		
Heart Attack/Surgery/Pacemaker			Diabetes		
High Blood Pressure			Gout		
Anemia			Blood Clot/Emboli		
Allergies			Infectious Diseases		
Osteoporosis			Vision/Hearing Problems		
Metal in Body/Surgical Implants			Thyroid/Goiter Problems		
Anxiety/Depression			Dizziness/Fainting		
Weight Loss/Gain			Hernia		
Bowel/Bladder Problems			Joint Replacement		

List all surgical procedures you have had:

Other Conditions:

Other Providers Currently Seeing

CONSENT FORM
INTERNAL PELVIC FLOOR EVALUATION

In order to fully understand the scope of your individual diagnosis, there is important information your physical therapist needs.

Please be brief in your answers. If your physical therapist needs to expand upon your answers, she will ask you privately.

	Yes	No
1. Are you currently sexually active?		
If "No", have you been in the past?		
2. Do you have any communicable diseases?		
If "Yes", please explain:		
3. Has there been any sexual abuse in your past?		
4. Have you had difficulty in the past with vaginal exams?		

I give / deny (circle one) my consent for the physical therapist to do a vaginal/rectal examination for the purpose of evaluating my condition and giving therapeutic treatment.

1. I understand I can terminate the procedure at any time.
2. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the procedure.
3. I have the option of bringing a second person to be in the room with me during the procedure, and I refuse / choose (circle one) this option.
4. I have read this consent form and understand its terms.

Signature of Patient or Guardian Date

Printed Name of Patient or Guardian

PELVIC QUESTIONNAIRE

PELVIC AND ABDOMINAL PAIN

WHERE IS YOUR PAIN: ☐Vagina ☐Vulva ☐ Pubic Bone ☐Tailbone ☐Sacrum☐SI Joint☐Lumbar ☐Hip(s) ☐Abdomen

DESCRIPTION: ☐None ☐Yes ☐Stabbing ☐Aching ☐Tender ☐Sore ☐Burning ☐Prickling ☐Sharp ☐Shooting

WHAT INCREASES YOUR PAIN:

WHAT DECREASES YOUR PAIN:

TIME OF DAY: ☐Unaffected MORNING: ☐Increase ☐Decrease AFTERNOON:☐Increase ☐Decrease
EVENING: ☐Increase ☐Decrease NIGHTTIME: ☐Increase ☐Decrease

FULL BLADDER: ☐Unaffected ☐Increase ☐Decrease

URINATION: ☐Unaffected ☐Increase ☐Decrease

BOWEL URGE: ☐Unaffected ☐Increase ☐Decrease

DURING BOWEL MOVEMENT: ☐Unaffected ☐Increase ☐Decrease

AFTER BOWEL MOVEMENT: ☐Unaffected ☐Increase ☐Decrease

VAGINAL PENETRATION: ☐N/A ☐Unaffected ☐Increase ☐Decrease

INITIAL PENETRATION: ☐N/A ☐Unaffected ☐Increase ☐Decrease

DEEP PENETRATION: ☐N/A ☐Unaffected ☐Increase ☐Decrease

ORGASM: ☐N/A ☐Unaffected ☐Increase ☐Decrease

FOLLOWING PENETRATION: ☐N/A ☐Unaffected ☐Increase ☐Decrease

ARE YOU ABLE TO ACHIEVE AN ORGASM ☐No ☐Yes ☐Unsure

MARINOFF SCALE - DESCRIPTIVE SCALE OF INTERCOURSE ☐N/A

☐0: No Problems ☐2: Pain interrupts or prevents completion
☐1: Discomfort that does not affect completion ☐3: Pain preventing any attempts at intercourse

CONTACT WITH CLOTHING: ☐Unaffected ☐Increase ☐Decrease

ABDOMINAL PAIN OR BLOATING: ☐N/A ☐No ☐Yes. explain:

DIGESTIVE ISSUES: ☐No ☐Past ☐Present. Explain:
☐Food Allergy or Intolerance ☐IBS ☐IBD ☐Leaky Gut ☐SIBO ☐Candida Overgrowth ☐Colon Dysbiosis
☐Ulcerative Colitis ☐Crohn's ☐Other:

PAIN FROM EATING: ☐No ☐Yes, explain:

PAIN FROM DRINKING: ☐No ☐Yes, explain:

RATE YOUR PAIN (0=NONE, 10=WORST PAIN IMAGINABLE)? Current:___**/10** At best?:___**/10** At worst?:___**/10**

OBSTETRICS/GYNECOLOGICAL HISTORY

ARE YOU CURRENTLY PREGNANT? ☐No ☐Yes. DUE DATE:__/__/__ NUMBER OF WEEKS GESTATION:
IF PREGNANT, ARE YOU HIGH RISK?☐No ☐Yes
DO YOU HAVE MTHFR?☐No ☐Yes, Explain:
CURRENT PRENATAL SUPPLEMENTS:
NUMBER OF PREGNANCIES:____ NUMBER OF DELIVERIES:___VAGINAL:___C-SECTION:___V-BAC:_____
DATES OF DELIVERIES:
BIRTH WEIGHTS:
CURRENTLY BREASTFEEDING? ☐No ☐Yes
EPISIOTOMY OR PERINEAL TEAR? ☐No ☐Yes, explain:
DIFFICULT CHILDBIRTH? ☐No ☐Yes, explain:
POST PARTUM DEPRESSION OR BABY BLUES? ☐No ☐Yes ☐Unsure, explain:
DO YOU HAVE DIASTASIS RECTI? ☐No ☐Yes ☐Unsure, explain:
DIFFICULTY CONCEIVING? ☐No ☐Yes, explain: # of Miscarriages:___# of Infant Losses:___# of Abortions:___
MENSTRUATION: ☐N/A CYCLE LENGTH:_____days PAINFUL PERIODS? ☐No ☐Yes, Explain: DURATION OF PERIOD (BLEEDING):____days
VAGINAL DRYNESS? ☐No ☐Yes, explain:
CURRENTLY ON BIRTH CONTROL? ☐No ☐Yes, Name: TOTAL MONTHS/YEARS ON BIRTH CONTROL:
DATE OF LAST PELVIC EXAM:__/__/__ RESULTS?:
HISTORY OF STD'S CURRENT OR PAST? ☐No ☐Yes, explain: IF PAST PLEASE LIST CURE DATE:__/__/__
CURRENT YEAST INFECTION?☐No ☐Yes HISTORY OF YEAST INFECTIONS?☐No ☐Yes. How Many?
CURRENT URINARY TRACT INFECTION (UTI)? ☐No ☐Yes HISTORY OF URINARY TRACT INFECTIONS?☐No ☐Yes. How Many?
DO YOU USE LATEX CONDOMS? ☐No ☐Yes
DO YOU USE VAGINAL LUBRICANTS? ☐No ☐Yes(Brand(s)?
DO YOU USE BATH SALTS, VAGINAL SPRAYS, DOUCHES?☐No ☐Yes, explain:
DO YOU USE ANY OTHER VAGINAL CREAMS OR MEDICINE? ☐No ☐Yes, explain:

BLADDER

WAS THERE AN EVENT ASSOCIATED WITH ONSET OR URINARY COMPLAINTS?: ☐No ☐ Yes, Please describe:
URINE STREAM: ☐Easy to start ☐Difficult to Start ☐Strong ☐Weak ☐Starts & Stops ☐Deflects to one side
EMPTYING: ☐Complete ☐Incomplete ☐Pushing or Straining needed ☐Retention ☐Other:
ANY DRIBBLING AFTER URINATION: ☐No ☐Yes
FREQUENCY OF URINATION: During awake hours?___# times per day During sleep hours? ___# times per night
DO YOU FEEL AN INTENSE URGE TO URINATE? ☐No ☐Yes ☐Unsure
URINARY SENSATION PRESENT: ☐No ☐Yes ☐Variable ☐Sense of “urgency” ONCE YOU GET THE URGE, CAN YOU HOLD BACK FROM VOIDING?: ___minutes, ___hours COLOR OF URINE?
WHAT IS THE AVERAGE VOLUME OF URINATION? (Specify ounces or count seconds) ☐___oz ☐___seconds
WHAT DO YOU DRINK?:
CUPS OF FL OZ OF WATER PER DAY?:
CAFFEINE?: ☐None ☐Yes, please describe:
CAN YOU STOP YOUR URINE ONCE STARTED? ☐Complete ☐Deflects ☐Unable
DO YOU KEGEL WHEN YOU URINATE? ☐No ☐Yes ☐Sometimes
PAIN OR BURNING WITH URINATION? ☐ No ☐Yes
PAIN WITH WIPING? ☐ No ☐Yes
HOW DO YOU WIPE? ☐Front to back ☐Back to front ☐Other, explain:
PROLAPSE OR FEELING OF FALLING OUT OR HEAVINESS IN PELVIS: ☐No ☐Yes ☐With Menses ☐Standing ☐Straining ☐At the end of the day ☐All the time
DO YOU VOID “JUST IN CASE”?: ☐No ☐ Yes
DO YOU HOVER OVER PUBLIC TOILETS TO VOID: ☐No ☐Yes
DID YOU EXPERIENCE ANY URINARY ISSUES AS A CHILD?: ☐No ☐Yes, please describe:
DID YOU EXPERIENCE ANY URINARY ISSUES AS A CHILD? ☐ No☐Yes, please describe:

URINARY LEAKAGE

URINARY LEAKAGE:___# episodes per ☐Day ☐Week ☐Month
Cause: ☐None ☐Cough ☐Sneeze ☐Laugh ☐Lift ☐Sit<>Stand ☐Walking ☐Jumping ☐Running ☐On the way to the bathroom ☐Sound of running water ☐Key in the door ☐Other:
URINE LEAKAGE AMOUNT: ☐None ☐Few Drops ☐Wets Pads ☐Wets Underwear ☐Wets outerwear
DO YOU WEAR A PAD OR PROTECTIVE DEVICE?: ☐No ☐Yes, What kind? # OF PAD CHANGES IN 24 HOURS?:
HAVE YOU EVER TAKEN MEDICINE TO PREVENT URINE LOSS?: ☐No ☐ Yes, explain:

BOWEL HABITS

WAS THERE AN EVENT ASSOCIATED WITH ONSET OF BOWEL COMPLAINTS?: ☐No ☐Yes, please describe:
BOWEL SENSATION PRESENT?: ☐No ☐Yes ☐Variable
CAN YOU HOLD BACK YOUR FECES IF NO BATHROOM IS AROUND? ___minutes, ___hours
FREQUENCY OF BOWEL MOVEMENTS: ___# of times per day, ___# of times per week
EVACUATION HABITS: ☐Hold Breathe ☐Straining ☐Splinting ☐Other, explain:
COLOR OF YOUR POOP:
IS YOUR STOOL: ☐Liquid ☐Soft ☐Normal ☐Firm ☐Hard
LAXATIVE USE: ☐None ☐Yes, how often per week?:
ANY BLOOD ON TISSUE AFTER BOWEL MOVEMENT: ☐No ☐Yes
DID YOU EXPERIENCE ANY BOWEL ISSUES AS A CHILD?: ☐No ☐Yes ,Please describe:
FECAL LEAKAGE:___# episodes per ☐Day ☐Week ☐Month CAUSE OF FECAL LEAKAGE: ☐N/A ☐Explain: FECAL LEAKAGE AMOUNT: ☐None ☐Smear ☐Diarrhea ☐Few “Pebbles” ☐Full Stool
FORM OF PROTECTION: ☐None ☐Yes, what type of pad?: # OF PAD CHANGES REQUIRED IN 24 HOURS:

LIFESTYLE / QUALITY OF LIFE / FUNCTIONAL LIMITATIONS

SOCIAL ACTIVITIES: ☐Unaffected ☐Affected, explain:
DIET/FLUID INTAKE:☐Unaffected ☐Affected, explain: CURRENT DIET:
DRUG, ALCOHOL, TOBACCO USE: ☐None ☐Yes, explain
PHYSICAL ACTIVITY:☐Unaffected ☐Affected, explain: CURRENT PHYSICAL ACTIVITY:
WORK: ☐N/A ☐Unaffected ☐Affected, explain: CURRENT JOB:
OTHER (SPECIFY): ☐N/A ☐Affected, explain:
PATIENT GOALS