PELVIC FLOOR REHABILITATION INTAKE SUMMARY

Name:_____ Date of Birth:_____ Today's Date:_____

Describe the problem that brings you to therapy: _____

Date problem began: _____

What is your goal for therapy? _____

Do you have pain? ❑ No ❑ Yes, please describe _____

Have you had any tests recently? (X-Ray, MRI, CT Scan, etc.)_____

Describe what you do to keep physically fit:_____

Do you live with: ❑ Spouse ❑ Child(ren) ❑ Parent(s)/Guardian ❑ Alone ❑ Other: _____

Are you currently working? ❑ No ❑ Yes, occupation: _____

Is there anything else you think your therapist will need to know?: _____

Do you have any difficulty with or are you compensating for any of the following activities?

Dressing:	❑ No	❑ Yes	Hygiene (bathing, toileting, grooming):	❑ No	❑ Yes
Walking:	❑ No	❑ Yes	Household activities:	❑ No	❑ Yes
Sitting:	❑ No	❑ Yes	Work activities:	❑ No	❑ Yes
Sleeping:	❑ No	❑ Yes	Skills with dominant arm:	❑ No	❑ Yes
Sexual Intercourse	❑ No	❑ Yes… with penetration? ❑ No ❑ Yes; and/or 2) with thrust?		❑ No	❑ Yes

Do you have any previous history or currently have any of the following conditions?

Pelvic or tailbone trauma:	❑ No	❑ Yes	Hemorrhoids / Fissures:	❑ No	❑ Yes
Currently sexually active:	❑ No	❑ Yes	Irritable Bowel Syndrome:	❑ No	❑ Yes
Sexually Transmitted Disease:	❑ No	❑ Yes	Fibroids / Cysts:	❑ No	❑ Yes
Frequent Bladder Infections:	❑ No	❑ Yes	Endometriosis:	❑ No	❑ Yes
Frequent Yeast Infections:	❑ No	❑ Yes	Inflammatory Bowel Disease:	❑ No	❑ Yes

Obstetric History

Date of Delivery or Miscarriage	Time Spent Pushing	Vaginal or Cesarean	Baby's Weight	Trauma or Complications

Past Medical History: Do you have any previous history of the following conditions?

High Blood Pressure:	❑ No	❑ Yes	Seizures:	❑ No	❑ Yes
Heart Condition/Pacemaker:	❑ No	❑ Yes	Severe Emotional Disturbance:	❑ No	❑ Yes
Strokes:	❑ No	❑ Yes	Persistent Night Pain:	❑ No	❑ Yes
Diabetes:	❑ No	❑ Yes	Cancer:	❑ No	❑ Yes
Broken Bones (Fractures):	❑ No	❑ Yes	Respiratory Disorders/Short of breath:	❑ No	❑ Yes
Metal Implants:	❑ No	❑ Yes	Excessive Fatigue:	❑ No	❑ Yes
Arthritis:	❑ No	❑ Yes	Frequent/Severe Headaches:	❑ No	❑ Yes
Fibromyalgia:	❑ No	❑ Yes	Unexplained Weight Loss/Gain:	❑ No	❑ Yes

Have you taken steroids for a prolonged period of time? ❑ No ❑ Yes

→→→→→→→ OVER →→→→→→→

PELVIC FLOOR REHABILITATION INTAKE SUMMARY

Languages you speak: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other _____
Preferred language for discussing healthcare: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other _____

Preferred Mode of communication: ❑ Verbal ❑ Sign Language ❑ Written ❑ Other_____

ALLERGIES Do you have any allergies? ❑ No ❑ Yes, please list:	**REACTION**

OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Do you have any other diagnoses or significant conditions? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**

PREVIOUS PROCEDURES / SURGERIES Did you have any other previous procedures / surgeries? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**

CURRENT MEDICATIONS, INCLUDING HERBALS Are you currently taking any medications, including herbals? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**
❑ See attached list			

Do you identify with another gender? ❑ No ❑ Yes, which gender do you identify with? _____

Physical Therapy Patients Only: If I am being evaluated by a Physical Therapist without a physician referral, I understand that any diagnosis made is a therapy diagnosis and not a medical diagnosis.

I acknowledge that the above is true to the best of my knowledge and am aware that if I miss three scheduled visits within the course of treatment that my treatment may be discontinued per therapist discretion.

_____ _____ _____
Time Date Patient Signature

PELVIC FLOOR REHABILITATION INTAKE SUMMARY

If you have any bowel or bladder issues, please answer the following:

How often do you urinate during the day?
- ❑ 1-3 times
- ❑ 4-7 times
- ❑ 8-10 times
- ❑ 11-15 times
- ❑ More than 15 times

How many times do you urinate at night?
- ❑ None / Rarely
- ❑ Once
- ❑ 2-3 times
- ❑ More than 3 times

How long can you hold urine once you have an urge?
- ❑ As long as I need to
- ❑ For about 30 minutes
- ❑ For a few minutes (2-5 minutes)
- ❑ For less than 2 minutes
- ❑ Cannot tell when full

When you urinate, do you feel the amount is:
- ❑ Small
- ❑ Medium
- ❑ Large

Do you feel you empty your bladder completely?
- ❑ No
- ❑ Yes

Are you able to stop your flow of urine by squeezing your pelvic floor muscles?
- ❑ No
- ❑ Yes

Do you have any urinary leakage?
- ❑ No
- ❑ Yes, frequency occurs…

_____ times per day _____ times per night
_____ times per week _____ times per month

How much urine do you lose during an accident?
- ❑ A few drops (small amount)
- ❑ Enough to spot clothing (medium amount)
- ❑ Most or all of the bladder (large amount)

What type of protection do you use?
- ❑ None
- ❑ Panty liner or minipad,_____changes per day
- ❑ Maxi or bladder pad, _____changes per day
- ❑ Diaper or depends,

Do you have frequent bladder infections?
- ❑ No
- ❑ Yes

What causes you to lose urine?
- ❑ Cough, laugh, or sneeze
- ❑ Physical activity
- ❑ Approaching a bathroom
- ❑ Other _____
- ❑ Hand washing
- ❑ Intercourse

Do you have difficulty during urination?
- ❑ Difficulty starting flow
- ❑ Strong urge/frequency
- ❑ Abnormal Color
- ❑ Other _____
- ❑ Straining to finish flow
- ❑ Slow, dribbling stream

How many 8 oz. glasses of water do you drink?
_____ glasses per day

Which "bladder irritants" do you consume? Quantity
- ❑ Alcohol _____
- ❑ Caffeinated beverages _____
- ❑ Decaffeinated beverages _____
- ❑ Chocolate _____
- ❑ Citric juices _____
- ❑ Alcohol _____
- ❑ Alcohol _____

Frequency of bowel movements: _____
Frequent constipation? ❑ No ❑ Yes
Frequent diarrhea? ❑ No ❑ Yes
Regular laxative use? ❑ No ❑ Yes
Bowel sensation present ❑ No ❑ Yes
Describe the shape of your stool:_____

Do you have any fecal leakage?
- ❑ No
- ❑ Yes

Fecal leakage amount:
- ❑ Small
- ❑ Medium
- ❑ Large

Do you wear a pad for this?
- ❑ No
- ❑ Yes

Do you have any known food allergies or sensitivities?
- ❑ None / Unknown
- ❑ Dairy
- ❑ Soy
- ❑ Peanuts
- ❑ Gluten
- ❑ Eggs
- ❑ Artificial dyes / sweeteners
- ❑ Other:_____

Do you experience:
- ❑ Frequent Gas
- ❑ Abdominal Pain
- ❑ Bloating

Please let us know about any other bowel or bladder problems that you are experiencing:

_____
_____
_____
_____