ORTHOPEDIC SPINE THERAPY

Pelvic Health & Therapy Intake Form

Please note that some questions are anatomy specific.
Answer which questions best suit your current anatomy.

Urinary Function

☐I estimate _____ voids per day & _____ per night.

☐I leak urine when I: ☐cough ☐sneeze ☐yell ☐jump ☐exercise ☐laugh ☐vomit ☐move from sitting to standing ☐other _____

☐I constantly leak urine.

☐I sometimes am unable to make it to the toilet in time because the urge is o strong that I leak urine.

☐Things that trigger my urge include: ☐running water ☐key in door ☐cold ☐the bathroom ☐other _____

☐I have a: ☐constant ☐intermittent stream of urine when I urinate.

☐I have difficulty: ☐starting ☐stopping my flow

☐I have to: ☐strain ☐self-cath to completely empty my bladder.

☐I do not feel like I completely empty my bladder when I urinate.

☐I wear _____ pads per day for my urinary incontinence.

☐I do daily pelvic floor exercises (kegels).

Bowel Function

☐I typically have _____ bowel movements per: ☐week ☐day.

☐I leak: ☐gas ☐stool.

☐I wear _____ pads per day for my fecal incontinence.

☐I have irritable bowel syndrome. I typically have: ☐constipation ☐diarrhea ☐mixed.

☐To manage constipation I use: _____

☐I sometimes am unable to make it to the toilet in time because the urge is so strong that I leak feces.

☐Things that trigger my urge include: ☐eating ☐caffeine ☐running water ☐key in door ☐cold ☐the bathroom ☐other _____

☐I have to splint my perineum with my hand when I have a bowel movement.

☐I have to manually evacuate stool on occasion.

☐I am experiencing rectal bleeding and/or blood in my stool.

Nutrition/Fluid Intake/Exercise

☐I drink _____ servings of water per day. (1 serving = 8 ounces)

☐I drink the following servings of beverages a day: _____ soda, _____ diet soda, _____ milk, _____ regular coffee, _____ decaf coffee, _____ tea, _____ alcohol, _____ other

☐I weigh _____ pounds. I have a _____ pound weight: ☐gain ☐loss goal.

☐I am currently dieting. The diet I am following is _____.

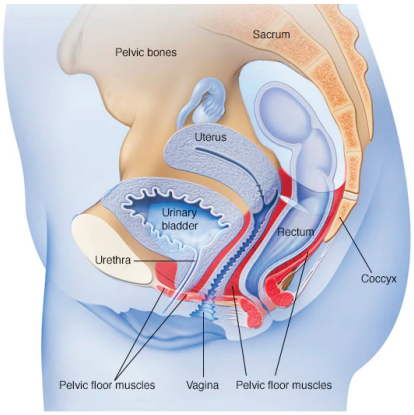
☐I exercise _____ times per week. I typically do the following exercises: _____

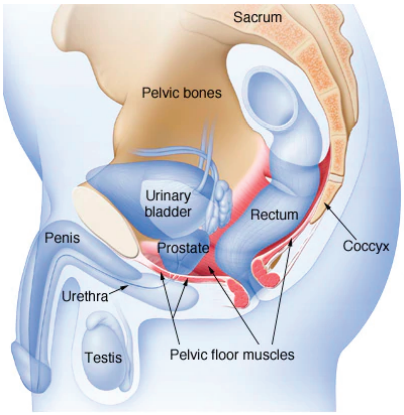
_____

☐I ☐have ☐had an eating disorder: ☐anorexia ☐bulimia ☐other _____

Pain & Sexual Health History

Please shade the areas of pain on the anatomy you have and write a number from 1 to 10 at the site(s) of pain. (10 = most severe)





☐ I do not have problems with pain.

☐ I have pain during ovulation.

☐ I have pain during menstruation.

☐ I am sexually active at this time.

☐ I am sexually inactive due to pain.

☐ I am sexually inactive for other reasons: _____

☐ I have pain with sexual activity: ☐At vaginal opening ☐Pelvic pain ☐Abdominal pain ☐Tailbone pain ☐Penis pain ☐Testicular pain ☐Back pain ☐With penetration ☐With erection ☐With ejaculation ☐With orgasm

☐ I have pain after sexual activity: ☐At vaginal opening ☐With urination ☐With bowel movements ☐With full bladder ☐With sitting ☐Pelvic pain ☐Rectal pain ☐Abdominal pain ☐Tailbone pain ☐Penis pain ☐Testicular pain ☐Back pain ☐Headache

Obstetric History

☐ I am not, nor have I ever been pregnant. *(If checked, please ignore the rest of the section.)*

☐ I am currently pregnant:

I am at _____ weeks gestation, with the due date of _____.

Concerns during this pregnancy? ☐ No ☐ Yes, _____

Has your physician placed you on any restrictions? ☐ No ☐ Yes, _____

☐ Number of pregnancies _____ (Including current, if applicable)

Number of vaginal deliveries _____ Number of cesarean deliveries _____ Number of episiotomies _____

Birth weights of children _____

☐ Have you suffered a miscarriage? ☐ No ☐ Yes, number of miscarriages _____

☐ Complications during pregnancy, labor, delivery or postpartum ☐ vacuum ☐ postpartum hemorrhaging ☐ forceps ☐ medication for bleeding ☐ postpartum depression ☐ preeclampsia ☐ other _____

Fill out this section ONLY if you have given birth within the last 12 weeks.

In the last 7 days:

I have blamed myself unnecessarily when things went wrong: ☐ Yes, all the time ☐ Yes, most of the time ☐ No, not very often ☐ No, not at all

I have felt panicky or scared for no good reason: ☐ Yes, all the time ☐ Yes, most of the time ☐ No, not very often ☐ No, not at all

I have been anxious or worried for no good reason: ☐ Yes, all the time ☐ Yes, most of the time ☐ No, not very often ☐ No, not at all

Gynecological History

☐ The first day of my last menstrual cycle was _____.

☐ I have not started my menstrual cycle yet.

☐ I have ☐ started ☐ completed menopause.

☐ If still menstruating, periods are: ☐ light ☐ moderate ☐ heavy ☐ bleed through protection

☐ History or current concern that you have: ☐ pelvic heaviness ☐ fibroids ☐ cysts ☐ endometriosis

☐ I am currently using the following birth control method: ☐ IUD ☐ birth control pill ☐ Depo Provera shot ☐ Nuva Ring ☐ condoms ☐ withdrawal ☐ other _____