ORTHOPEDIC SPINE THERAPY

Pelvic Health Intake Form

Name _____ Date _____

DOB _____ Age _____

What is your gender? _____ What sex were you assigned at birth? _____

URINARY FUNCTION

I estimate _____ urinations per day & _____ per night.

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

I constantly leak urine: ☐ Yes ☐ No ☐ Sometimes

I am unable to make it to the toilet in time because the urge is so strong that I leak urine:
☐ Yes ☐ No ☐ Sometimes

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

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

I have difficulty ☐ starting ☐ stopping **my flow.**

I have to ☐ strain ☐ self-cath ☐ none **to completely empty my bladder.**

I empty my bladder when I urinate: ☐ Yes ☐ No ☐ Sometimes

I wear pads for my urinary incontinence: ☐ Yes **How Many?** _____ ☐ No ☐ Sometimes

I do pelvic floor exercises (kegels): ☐ Yes ☐ No ☐ Sometimes

BOWEL FUNCTION

I typically have _____ bowel movements per ☐ week ☐ day

I leak: ☐ gas ☐ stool ☐ none

I wear pads for my fecal incontinence: ☐ Yes **How Many?** _____ ☐ No ☐ Sometimes

I have irritable bowel syndrome: ☐ Yes ☐ No

I typically have ☐ constipation ☐ diarrhea ☐ mixed

To manage constipation I use _____

I am unable to make it to the toilet in time because the urge is so strong that I leak feces:
☐ Yes ☐ No ☐ Sometimes

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

I have to splint my perineum with my hand when I have a bowel movement:
☐ Yes ☐ No ☐ Sometimes

I have to manually evacuate stool on occasion: ☐ Yes ☐ No ☐ Sometimes

I am experiencing rectal bleeding and/or blood in my stool: ☐ Yes ☐ No ☐ Sometimes

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NUTRITION, FLUID & EXERCISE INTAKE

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

I drink the following servings of beverages a day:

☐soda_____ ☐decaf coffee_____ ☐diet soda_____ ☐tea_____
☐milk_____ ☐alcohol_____ ☐regular coffee____ ☐other____

I weigh _____ pounds

I am currently dieting: ☐ Yes **What diet? _____** ☐ No

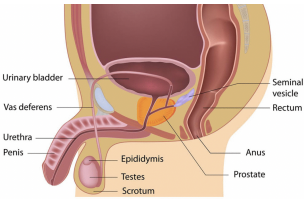
I exercise _____ times per week.

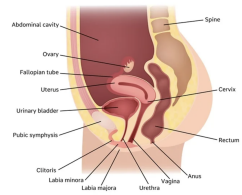
I typically do the following exercises: _____

I have had/have an eating disorder: ☐ anorexia ☐ bulimia ☐ none ☐ other _____

PAIN & SEXUAL HEALTH HISTORY

Please circle the areas of pain on the pictures below. Rate your pain on a scale of 1-10 at the site(s) of pain. (10 = most severe)





I have problems with pain: ☐ Yes ☐ No ☐ Sometimes
I am sexually active at this time: ☐ Yes ☐ No ☐ Sometimes
I am sexually inactive due to pain: ☐ Yes ☐ No ☐ Sometimes
I am sexually inactive for other reasons: ☐ Yes ☐ No ☐ Explain _____

Please answer the following if it applies to you:

Biological Female:

My pain is worse with ovulation: ☐ Yes ☐ No ☐ Sometimes
I have pain during my period: ☐ Yes ☐ No ☐ Sometimes

I have pain during intercourse: ☐ my pain feels close to the vaginal opening ☐ pain with orgasm ☐ my pain feels deep inside me ☐ other_____

I have pain after intercourse: ☐ when my bladder is full ☐ burning vaginal pain after sex ☐ backache ☐ pain with sitting ☐ muscle/joint pain ☐ pain with urination ☐ migraine ☐other_____

Biological Male:

My pain is worse during an erection: ☐ Yes ☐ No ☐ Sometimes
My pain is worse during ejaculation: ☐ Yes ☐ No ☐ Sometimes
My pain lingers after ejaculation for _____ ☐ days ☐ hours ☐ minutes
My pain is located: ☐ rectal area ☐ penis ☐ testicles ☐ my pain feels deep inside ☐ abdomen ☐ behind testicle ☐ buttock

I have pain after intercourse. This pain includes:
☐ backache ☐ when my bladder is full ☐ pain with sitting ☐ muscle/joint pain ☐ pain with urination ☐ migraine headache ☐ other _____

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Please answer the following if it applies to you:

GYNECOLOGICAL HISTORY

The first day of my last menstrual cycle was: _____

Have you currently started your menstrual cycle? ☐ Yes ☐ No

During menstruation, my periods are: ☐ light ☐ heavy ☐ moderate ☐ bleed through protection

I have ☐ started ☐ not started ☐ completed **menopause**

Do you use birth control? ☐ Yes ☐ No

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

Do you have history or a current medical concern? (including pelvic heaviness, fibroids, cysts, or endometriosis)

_____

OBSTETRIC HISTORY

Number of pregnancies: _____ (including current, if applicable)
vaginal deliveries _____ miscarriages _____
cesarean deliveries _____ abortions _____ episiotomies_____

What complications did you experience during pregnancy during labor, delivery, or postpartum?
☐ vacuum ☐ medication for bleeding ☐ forceps ☐ postpartum hemorrhaging ☐ perineal tearing ☐ postpartum depression ☐ preeclampsia ☐ other_____

I am currently pregnant: ☐ Yes ☐ No

If answered no, please skip this section.

I'm at _____ weeks gestation, with the due date of _____

Do you have concerns during this pregnancy?

_____

Has your physician placed you on any restrictions?

_____

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

IN THE LAST 7 DAYS
I have blamed myself unnecessarily when things go 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