ORTHOPEDIC & SPINE THERAPY PELVIC HEALTH INTAKE FORM

URINARY FUNCTION *(Please check and circle all that apply)*:

❒ I estimate _____ (#)voids per day / _____ (#)voids per night,
❒ I leak urine when I(*please circle all that apply*): 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 so strong that I leak urine.
❒ Things that trigger my urge include (*please circle all that apply*): running water / key in door / cold / the bathroom / other_____.
❒ I have a (*choose one*) constant / intermittent stream of urine when I urinate.
❒ I have difficulty (*please circle all that apply*) starting / stopping my flow.
❒ I have to (*please circle all that apply*) 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).

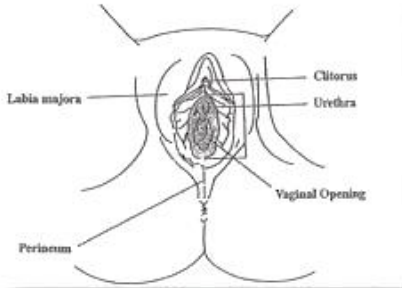
BOWEL FUNCTION *(Please check and circle all that apply)*:

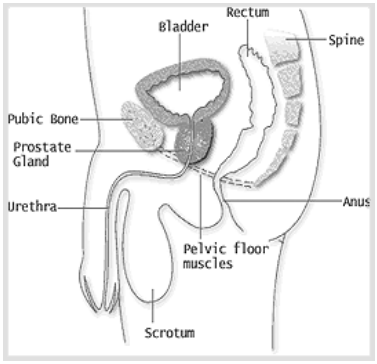
❒ I typically have _____(#)bowel movements per week / day (*circle one*).
❒ I leak (*please circle all that apply*) gas / stool.
❒ I wear _____ (#)pads per day for my fecal incontinence.
❒ I have irritable bowel syndrome. I typically have (*circle one*) constipation / diarrhea / mixed.
❒ To manage constipation 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 (*please circle all that apply*: 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 occasionally.
❒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 oz)
❒ I drink the following beverages (# servings) soda_____,diet soda_____,milk_____,regular coffee_____, tea_____, decaf coffee_____, juice_____,alcohol_____,other_____.
❒ I weigh _____ (#)pounds. I have a _____(#)pound weight loss/gain goal.
❒ I am currently dieting. The diet I am following is_____.
❒ I exercise _____(#)times per week. I typically walk (# times per week)_____/ run_____ / elliptical _____/cycle_____ / lift weights_____ / swim _____/ row_____ / do exercise classes _____/ do exercise videos_____ / yoga_____ / Pilates_____ / other _____.
❒I have/ had an eating disorder: ❒ anorexia ❒bulimia ❒other _____.

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





PAIN HISTORY *(Please check, circle or complete all that apply)*:

❒ I do not have problems with pain. *Please ignore the rest of this section.*
❒ I am sexually active at this time.
❒ I am sexually inactive due to pain.
❒ I am sexually inactive for other reasons.

MALES:

❒ My pain is worse during an erection.
❒ My pain is worse during ejaculation.
❒ My pain lingers after ejaculation for _____ days/hours/minutes.
❒ My pain is located: ❒ rectal area ❒penis ❒testicles ❒behind testicle ❒buttock ❒abdomen ❒My pain feels deep inside.
❒ I have pain after intercourse.
❒ When my bladder is full ❒Muscle/joint pain ❒Pain with urination ❒Backache ❒Migraine headache ❒Pain with sitting

FEMALES:

❒ My pain is worse during ovulation.
❒ My pain is worse just before my period.
❒ I have pain with intercourse.
❒ My pain feels close to the vaginal opening ❒My pain feels deep inside ❒Pain with orgasm ❒Other _____
❒ I have pain after intercourse.
❒ When my bladder is full ❒Muscle/joint pain ❒Burning vaginal pain after sex ❒Pain with urination ❒Backache ❒Migraine headache ❒Pain with sitting ❒Other_____

OBSTETRIC HISTORY *(Please check, circle or complete all that apply)*:

❒ I am not, nor have not ever been pregnant. *Please ignore the rest of the section and continue below*.*
❒ I am currently pregnant.
I am at ____weeks gestation, with the due date of _____.
❒Any concerns during this pregnancy? ❒No ❒Yes If yes, please specify:_____
❒Has your physician placed you on any restrictions? ❒No ❒Yes If yes, please specify: _____
❒ Number of pregnancies____ (including current if applicable)
❒ Number of vaginal deliveries____. Birth weights:_____
❒ Number of cesarean deliveries____ Birth weights:_____
❒ Number of episiotomies____
❒ Number of miscarriages____ Date(s):_____
❒ Complications during pregnancy, labor, delivery or post-partum?
❒Vacuum ❒Post-partum hemorrhaging ❒Forceps ❒Medication for bleeding ❒Post-partum depression
❒ Preeclampsia ❒Other _____

GYNECOLOGICAL HISTORY *(Please check, circle or complete all that apply)*:

❒ The first day of my last menstrual cycle was: _____.
❒ I have not started my menstrual cycle yet.
❒ I have started / completed (*Please circle one)* menopause.
❒If still menstruating, periods are: ❒Light ❒Moderate ❒Heavy ❒Bleed through protection
❒Any history of or currently have feelings of: ❒pelvic heaviness ❒fibroids ❒cysts ❒endometriosis

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Fill out this section ONLY of you have given birth in the last 12 weeks.
Answer the following 3 questions by placing a check mark next to your response:
IN THE LAST 7 DAYS:

I have blamed myself unnecessarily when things went wrong.	I have felt panicky or scared for no very good reason.	I have been anxious or worried for no good reason.
_____Yes, all the time	_____Yes, all the time	_____Yes, all the time
_____Yes, most of the time	_____Yes, most of the time	_____Yes, most of the time
_____No, not very often	_____No, not very often	_____No, not very often
_____No, not at all	_____No, not at all	_____No, not at all