ORTHOPEDIC & SPINE THERAPY

PELVIC HEALTH INTAKE FORM

Name _____ Date _____

DOB _____ Age _____

URINARY FUNCTION

I estimate _____ voids 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 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
- ☐ Other _____
- ☐ key in the door
- ☐ the bathroom

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

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

I have to ... ☐ strain ☐ self-cath **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

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BOWEL FUNCTION

I typically have _____ bowel movements per ◯ week ◯ day

I leak ☐ gas ☐ stool

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 sometimes 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 ☐ Other _____
☐ caffeine ☐ running water ☐ the bathroom

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 _____
- ☐ diet soda _____
- ☐ milk _____
- ☐ regular coffee _____
- ☐ decaf coffee _____
- ☐ tea _____
- ☐ alcohol _____
- ☐ other _____

I weigh _____ **pounds.**

I am currently dieting. ◯ Yes **What diet?** _____ ◯ No

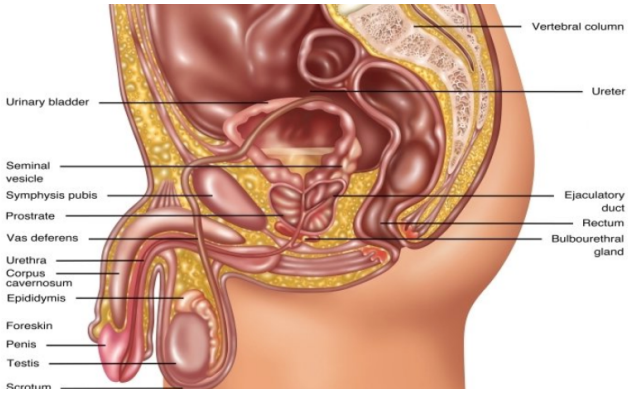
I exercise _____ **times per week.**

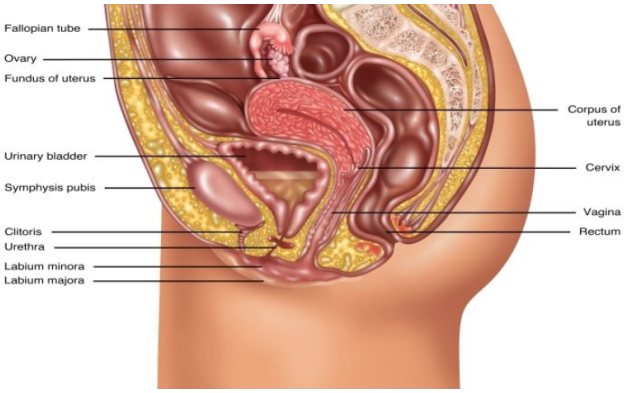
I typically do the following exercises: _____

I have had/have an eating disorder. ☐ anorexia ☐ bulimia ☐ other _____

PAIN & SEXUAL HEALTH HISTORY

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





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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 _____

MALES:

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
- ☐ other _____
- ☐ muscle/joint pain
- ☐ pain with urination
- ☐ migraine headache

FEMALES:

I have pain during ovulation. ◯ Yes ◯ No ◯ Sometimes

My pain is worse during ovulation. ◯ Yes ◯ No ◯ Sometimes

I have pain during my period. ◯ Yes ◯ No ◯ Sometimes

My pain is worse just before my period. ◯ Yes ◯ No ◯ Sometimes

ORTHOPEDIC & SPINE THERAPY

PELVIC HEALTH INTAKE FORM

I have pain during intercourse.

- ☐ my pain feels close to the vaginal opening
- ☐ my pain feels deep inside me
- ☐ 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
- pain with sitting
- other_____

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
- ☐ moderate
- ☐ heavy
- ☐ bleed through protection

Do you use birth control? ◯ Yes ◯ No

I am currently using the following birth control method:

- ☐ IUD
- ☐ condoms
- ☐ birth control pill
- ☐ Depo Provera shot
- ☐ Nuva Ring
- ☐ withdrawal
- ☐ other_____

I have not started menopause. ◯ Yes ◯ No

I have ◯ started ◯ completed menopause.

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

_____

_____

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PELVIC HEALTH INTAKE FORM

OBSTETRIC HISTORY

I am currently pregnant. ○ Yes ○ No ○ have been

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?

_____

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 ☐ other _____

☐ postpartum hemorrhaging ☐ postpartum depression ☐ preeclampsia

*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