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 _____ **voids per day &** _____ **per night.**

I leak urine when I:

☐ cough ☐ yell ☐ exercise ☐ sneeze ☐ move from sitting to standing

☐ jump ☐ laugh ☐ vomit ☐ Other _____

I constantly leak urine. ○ Yes ○ No ○ Sometimes

I sometimes 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

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

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

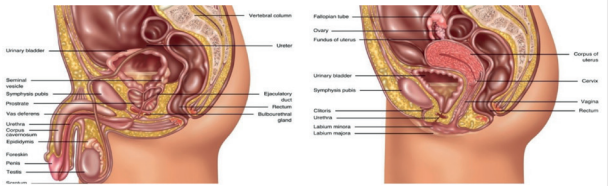
I exercise _____ **times per week.**

I typically do the following exercises: _____

I have had/have an eating disorder. ☐ anorexia ☐ bulimia ☐ 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)



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 _____

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 ☐ other _____

☐ muscle/joint pain ☐ pain with urination ☐ migraine headache

Biological Female:

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

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 _____

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

Do you use birth control? ○ Yes ○ No

I am currently using the following birth control method:

☐ IUD ☐ birth control pill ☐ Nuva Ring ☐ other_____

☐ condoms ☐ Depo Provera shot ☐ withdrawal

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)

_____

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