kitsap physical therapy

## Health Information

**Self-rate general health:**

❑ excellent ❑ fair ❑ poor

**Describe your activity level / exercise routine:**

_____

_____

**What is your stress level?**

❑ Low ❑ Medium ❑ High

**Are you seeing any other health professionals for this condition?**_____

## Surgical / Procedure History

❑ surgery for back/spine
❑ surgery for brain
❑ surgery for female organs
❑ surgery for abdominal organs
❑ surgery for bones/joints
❑ surgery for bladder/rectum

## Ob / Gyn History

❑ episiotomy or instrumented deliveries: #____
❑ pregnancies: #____
❑ vaginal delivery: #____
❑ c-section delivery: #____
❑ vaginal dryness
❑ painful periods
❑ menopause: *when-* ____
❑ vaginal tearing

Are you currently breastfeeding or pregnant? **YES** **NO**

Weight of largest baby at birth: _____

## General Medical History

Have you ever had any of the following? (check all that apply):

❑ pelvic organ prolapse
❑ sexually transmitted diseases
· hip or tailbone pain
❑ low back pain
❑ pelvic pain
❑ childhood bladder problems
❑ smoking history
❑ alcohol/drug problems
❑ depression
❑ frequent urinary or yeast infections
❑ irritable bowel syndrome
❑ stroke
❑ cancer
❑ acid reflux/belching
❑ osteoporosis
❑ chronic fatigue syndrome
❑ fibromyalgia
❑ anorexia/bulimia
❑ kidney disease
❑ urinary tract infections
❑ hepatitis
❑ headaches
❑ diabetes
❑ asthma
❑ allergies
❑ latex sensitivity
❑ hypo / hyperthyroid

**Have you ever been taught or told to do pelvic floor exercises or Kegels before?** ❑ YES ❑ NO

## Occupational Information

**Occupation:** _____

❑ full time ❑ retired ❑ unemployed
❑ homemaker ❑ retired ❑ student

**On average, how much time per day do you spend:**

| | | | | |
|---|---|---|---|---|
| Sitting | ❑0-3 hrs | ❑3-6 hrs | ❑6-8hrs | ❑>8hrs |
| Standing | ❑0-3 hrs | ❑3-6 hrs | ❑6-8hrs | ❑>8hrs |
| Computer | ❑0-3 hrs | ❑3-6 hrs | ❑6-8hrs | ❑>8hrs |
| Sleeping | ❑0-3 hrs | ❑3-6 hrs | ❑6-8hrs | ❑>8hrs |
| Driving | ❑0-3 hrs | ❑3-6 hrs | ❑6-8hrs | ❑>8hrs |

# Women's Pelvic Dysfunction Intake Form

**NAME:** _____ **DATE:** _____

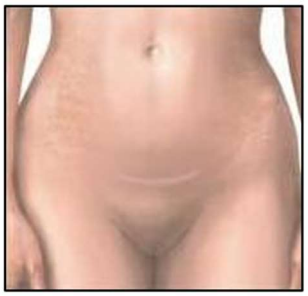
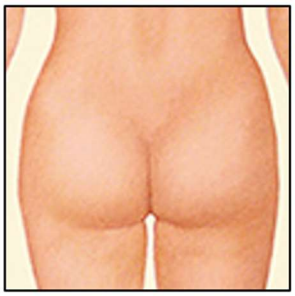
## Present Condition History

1. Describe your main problem or reason for your visit:

_____

_____

On the diagram below, please indicate where your current pain or problem is located:

2. When did it begin? *(please indicate a specific date if possible)*_____

3. Since onset, are your symptoms getting: (check one)

❑ staying the same ❑ getting worse ❑ getting better

4. Rate the degree of bother or severity of this problem from 0-10 (*0 being no problem and 10 being the worst*): _____

5. 1 in 4 women have been in an abusive situation (physically or emotionally threatened, insulted, beaten, injured or made to take part in sexual activities against your will). Have you ever been or are you now in an abusive situation? ❑ YES ❑ NO

## Pain and Sexual Function

6. Pain: Do you experience an increase in your pain with any of the following: (check all that apply)

❑ Sexual intercourse*: Initial entry, deep thrust, or both?*_____
❑ Certain Postures (sitting, standing, etc), or positions?
_____
❑ With a specific activity or exercise?
_____
❑ At a certain time of day?
_____
❑Other:
_____

7. If you have pain, describe it: *(stinging, burning, ripping, friction, throbbing)*_____

8. What do you do to alleviate your pains?

_____

_____

9. Please use a scale of 0 (no pain) to 10 (worst pain):
Current pain: _____ Worst Pain: _____ Least Pain: _____

10. Are you sexually active? ❑ YES ❑ NO
11. Do you have sexual desire? ❑ YES ❑ NO
If yes, can you get aroused? ❑ YES ❑ NO
Can you reach orgasm? ❑ YES ❑ NO

## Bladder Activity

12. Frequency of urination: ____ times during the day and ____ times at night.

13. Do you experience any leakage of urine or feeling of urgency during any of the following:

- ❑ Coughing, laughing, or sneezing
- ❑ On the way to the bathroom
- ❑ When pregnant or post-partum
- ❑ Immediately after using the bathroom
- ❑ With running water
- ❑ With sexual intercourse
- ❑ Exercising or running
- ❑ As a child (including bed wetting)
- ❑ Other: _____

14. How often do you leak urine?

- ❑ no leakage
- ❑ ____ times per day
- ❑ ____ times per week
- ❑ ____ times per month

15. On average, how much urine do you leak?:

- ❑ no leakage
- ❑ wets underwear
- ❑ wets the floor
- ❑ just a few drops
- ❑ wets outerwear

16. Do you ever experience:

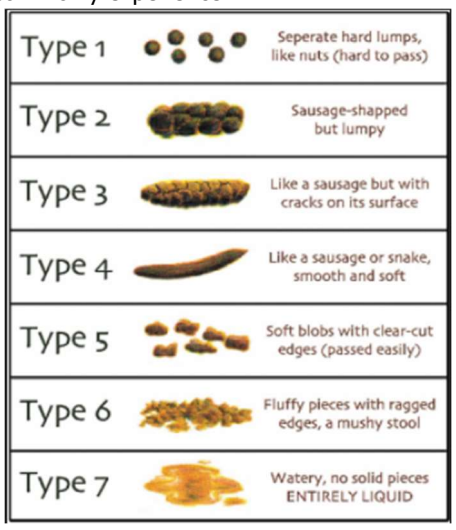
- ❑ difficulty initiating urine stream when ready to empty
- ❑ painful urination
- ❑ urinary intermittent/slow stream
- ❑ sense of not emptying bladder completely
- ❑ weak or intermittent stream
- ❑ blood in urine/stool
- ❑ diarrhea / gas

## Bowel Activity

17. Frequency of bowel movements: ____ times during the
- ❑ day
- ❑ week

18. It generally takes me ____ minutes to have a bowel movement, and I: ❑ *never* ❑ *sometimes* ❑ *often* have to strain to empty my bowels.

20. Bristol Stool Form Scale - Please circle which type of stool you most commonly experience:




21. If constipation is present, describe management techniques and/ or laxative use:

_____

22. When you have an urge to have a bowel movement, the amount of time you can delay before you have to go to the toilet is:

- ❑ ____ minutes
- ❑ ____ hours
- ❑ none at all

23. Bowel leakage: number of episodes: (please check one)

- ❑ no leakage
- ❑ ____ times per day
- ❑ only with physical exertion/strong urge
- ❑ ____ times per week
- ❑ ____ times per month

24. On average, how much stool do you lose?:

- ❑ no leakage
- ❑ small amount in underwear
- ❑ other _____
- ❑ stool staining
- ❑ complete emptying

## Other Bowel / Bladder

25. If appropriate, rate a feeling of organ "falling out"/prolapse or pelvic heaviness/pressure:

- ❑ none present
- ❑ ____ times per month (specify if related to activity or menstrual period)
- ❑ with standing for ____ minutes / hours
- ❑ with exertion or straining
- ❑ other _____

26. What form of leakage protection do you wear, and how many changes are required in 24 hours?: (please check one)

- ❑ none
- ❑ minimal protection; #____ (tissue paper/paper towel/pantishield)
- ❑ moderate protection; #____ (absorbent product/maxi pad)
- ❑ maximum protection; #____ (special product/diaper)

## Diet / Fluids

27. Average fluid intake includes ____ (8 oz) glasses per day, ____ of which are caffeinated or have artificial sweetener.

28. I have been told or suspect that I am intolerant to the following foods / drinks: _____
_____

29. Since the onset of your current symptoms, have you had:

- ❑ fever / chills
- ❑ numbness
- ❑ weakness
- ❑ unusual fatigue
- ❑ numbness in genital / anal areas
- ❑ nausea
- ❑ any dizziness or fainting attacks
- ❑ vomiting
- ❑ unexplained weight change
- ❑ headaches
- ❑ malaise--vague feeling of bodily discomfort

## Medications

List all medications including over-the-counter, vitamins, and supplements.

**Med name** **Start Date** **Reason for taking**

_____
_____
_____
_____

List the goals you would hope to achieve with physical therapy:

_____
_____
_____
_____