LIBERTY HOSPITAL
SPORTS MEDICINE
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Pelvic Health Intake Form

Name _____ **Preferred Name/Pronouns** _____

Briefly describe the problem that brought you in today, how it began, and when. _____

_____

Have you had similar problems/symptoms in the past? ☐ Yes ☐ No When? _____

Was your first episode of the problem related to a specific incident? ☐ yes ☐ no Explain _____

Since that time, the problem is ☐ staying the same ☐ getting worse ☐ getting better

Indicate dates of exams with specialists (urologists, gastroenterologists, ob/gyns) _____

Rate your current level of stress. ☐ low ☐ medium ☐ high **Currently in counseling/therapy** ☐ yes ☐ no

Occupation _____ Hours/week _____

Activity/Exercise _____ Times/week Type_____

Please check the corresponding box to indicate if you have or have had any of the following conditions.

☐ Currently ____ weeks pregnant	☐ Lymphedema	☐ Kidney disease
☐ Latex allergy	☐ TMJ/neck pain	☐ Alzheimer's disease/dementia
☐ Anxiety/depression	☐ Rheumatoid arthritis	☐ High or low blood pressure
☐ History of abuse (physical or sexual)	☐ Osteoarthritis	☐ Eating disorder
☐ Breastfeeding	☐ Osteoporosis/osteopenia	☐ Acid reflux/ulcers
☐ Irritable bowel syndrome	☐ Scoliosis	☐ Hernia
☐ Constipation	☐ Headaches/migraines	☐ Asthma/breathing disorders
☐ Postpartum depression	☐ Multiple sclerosis	☐ Hearing loss/problems
☐ Childhood bladder problems	☐ Seizures/epilepsy	☐ Vision/eye problems
☐ Psychiatric disorder _____	☐ TIA/CVA/stroke	☐ Anemia
☐ Traumatic brain/head injury	☐ Alcohol/substance abuse	☐ Diabetes
☐ Thyroid disorder	☐ HIV/AIDS	☐ Cancer (type) _____
☐ Heart conditions _____	☐ Sexually transmitted disease	☐ Other _____
☐ Fibromyalgia	☐ Frequent falls	☐ Allergies _____
☐ Autoimmune disease _____	☐ Joint replacement _____	

Indicate surgical history below by checking all that apply.

☐ back/spine ☐ hysterectomy ☐ bones/joints ☐ mastectomy ☐ gallbladder/appendix removed
☐ brain ☐ bladder/prostate ☐ abdominal organs ☐ hernia repair ☐ other_____

Female – Indicate history by checking all that apply.

☐ # of vaginal deliveries _____ ☐ # of c-sections _____ ☐ vaginal dryness ☐ painful vaginal penetration
☐ # of episiotomies _____ ☐ difficult childbirth ☐ painful periods ☐ pelvic organ prolapse
☐ date menopause began _____ ☐ pelvic pain ☐ other _____

List (or provide list of) all current prescription and over the counter medications/supplements and reason for taking.

_____
_____
_____
_____

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IF PAIN IS NOT PRESENT – SKIP THIS SECTION

If pain is present, please rate on a scale of 0 – 10. 0 is no pain. 10 is worst pain you can imagine. _____

When did your pain begin? _____ **Since it started, pain is** ☐ worse ☐ better ☐ same

Current level of pain _____ **Worst level of pain in last three days** _____ **Best level of pain in last three days** _____

Describe your pain: _____

What makes pain better? _____ **What makes the pain worse?** _____

BLADDER AND BOWEL SYMPTOMS

Please check any of the pelvic symptoms you are experiencing.

☐ trouble initiating urine stream	☐ trouble feeling bladder urge/fullness	☐ trouble holding back gas/feces
☐ trouble emptying bladder	☐ dribbling after urination	☐ current laxative use
☐ trouble emptying bladder completely	☐ painful urination	☐ recurrent bladder infections
☐ straining/pushing to empty bladder	☐ recurrent diarrhea	☐ constipation/straining
☐ frequent abdominal bloating	☐ pain with bowel movements	☐ other _____

Frequency of urination *Awake hours* _____ times per day *Sleep hours* _____ times per night

When you have a normal urge to urinate, how long are you able to delay before you have to use the toilet?

_____ minutes _____ hours or ☐ I can't wait

The usual amount of urine passed is ☐ small ☐ medium ☐ large

Frequency of bowel movements _____ times per day _____ times per week other _____

When you have an urge to have a bowel movement, how long are you able to delay before you have to use the toilet?

_____ minutes _____ hours or ☐ I can't wait

If constipation is present, please describe management techniques _____

Do you have the feeling of an organ "falling out"/prolapse or pelvic heaviness/pressure? ☐ yes ☐ no

Indicate average fluid intake (one cup is 8 oz) _____ cups/day **Indicate how many of these cups are caffeinated** _____

IF NOT EXPERIENCING LEAKAGE OR INCONTINENCE OF BLADDER OR BOWEL, PLEASE SKIP THIS SECTION.

I am experiencing bladder leakage. ☐ yes ☐ no

Number of episodes ____ Times/day ____ Times/week _____ Times/month

On average, how much urine do you leak? ☐ a few drops ☐ wets underwear ☐ wets outerwear ☐ wets floor

What activities cause you to have urine leakage? _____

I am experiencing bowel leakage. ☐ yes ☐ no ☐ only with exertion/strong urge

Number of episodes ____ Times/day ____ Times/week _____ Times/month

On average, how much stool do you lose? ☐ stool staining ☐ small amount in underwear ☐ complete emptying

Indicate what form of protection you wear. ☐ none ☐ minimal (tissue/paper towel/panty shield)

☐ moderate (absorbent product/maxipad) ☐ maximum (specialty product/diaper)

Indicate, on average, how many pad/protection changes are required in 24 hours. _____ # of pads

Please indicate what you would like to achieve through therapy. _____

Please indicate any concerns you have about receiving therapy. _____

Are there any beliefs, values, rules, or customs that the therapist needs to consider when treating you?

_____

Patient Signature_____ **Date**_____

Therapist Signature _____ **Date** _____