CALIFORNIA HAND & PHYSICAL THERAPY, INC

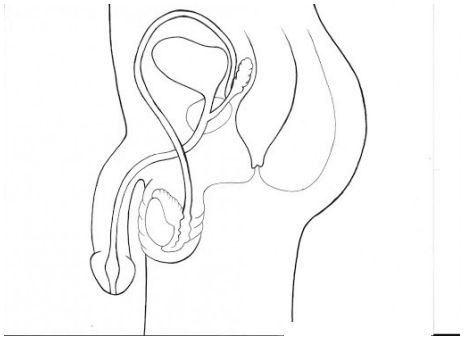
Pelvic Health Intake Form

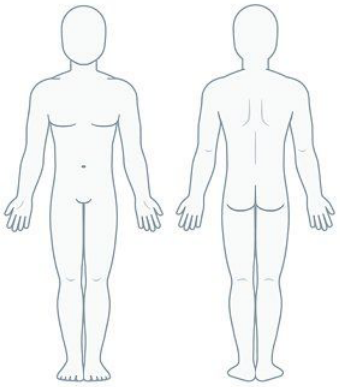
Date:	Referred By:	
Name:	Age:	DOB:
Address:	Cell #:	
City/State/Zip:	Email:	
Are you currently working? Yes or No	What is your occupation?	

Describe the symptoms that bring you to Pelvic Phyical Therapy today:

When were these symptoms first noticed?

Please shade the areas that are bothering you:





Overall, how would you rate your pain on a scale of 0-10 (0 being no pain at all and 10 being the worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

On a scale of 0-10, how much do these symptoms bother you on a daily basis? (0 no bother and 10 significantly bothered)

0 1 2 3 4 5 6 7 8 9 10

ON A SCALE OF 0-10, PLEASE RATE YOUR ABILITY TO PERFORM EACH TASK. 0 IS ABLE TO PERFORM WITH NO DIFFICULTY AND 10 IS UNABLE TO PERFORM AT ALL.

Self-Care 0 1 2 3 4 5 6 7 8 9 10	Caretaking 0 1 2 3 4 5 6 7 8 9 10
Sitting 0 1 2 3 4 5 6 7 8 9 10	Household Chores 0 1 2 3 4 5 6 7 8 9 10
Standing 0 1 2 3 4 5 6 7 8 9 10	Work 0 1 2 3 4 5 6 7 8 9 10

Name:

Walking 0 1 2 3 4 5 6 7 8 9 10	Leisure/Play 0 1 2 3 4 5 6 7 8 9 10
Lifting greater than 10 pounds 0 1 2 3 4 5 6 7 8 9 10	Driving 0 1 2 3 4 5 6 7 8 9 10
Exercising 0 1 2 3 4 5 6 7 8 9 10	

Do you have a medical diagnosis?
Are you under medical or therapeutic treatment? Yes or No
If yes, what treatments?
Any precautions the therapist should be aware of?
Please list any medications and supplements that you are taking and their intended uses:
Please list any surgeries you have had both medical and cosmetic:
Any significant injuries (accidents, fractures, etc.) & when did this occur:

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH MAY APPLY TO YOU OR PUT A 'P' IF THEY HAVE OCCURRED IN THE PAST:

ADHD	TMJ
Allergies	Constipation/Diarrhea/Both
Anemia	Diabetes
Anxiety/Depression/Panic	Digestive Problems
Arthritis: Rheumatoid or Osteoarthritis	Dizziness/Vertigo
Asthma/Breathing Difficulties	Eating Disorders
Bipolar Disorder	Fibromyalgia
Bladder Issues (urgency, frequency, blood)	Headaches/Migraines
Cancer/Type_____	Learning Disabilities
Cardiovascular/High Blood Pressure	Neurological Condition (MS, Stroke, Parkinsons, etc)
Chronic Fatigue	Osteoporosis
Chronic Pain: Circle Areas Affected Below:	Seizures
Face Neck Shoulders Upper Back	Sinus Infections
Pelvis Lower Back Tailbone	Sleep Disorder

FEMALE HEALTH HISTORY

Vaginal Deliveries # _____	C-Section # _____	Miscarriages # _____	D&C # _____
Endometriosis	Interstitial Cystitis	Scars/Episiotomy	Prolapse

Name:

Dryness	Please describe your menstruation: Light Cycle Regular Cycle Heavy Cycle Painful Cycle No Cycle	Menopause: Yes or No
Describe your symptoms of Menopause, if applicable:		

PELVIC FLOOR FUNCTIONS:

The Pelvic Floor has four main functions: stability for the entire body, bladder and bowel function, and sexual health. This section will help give us a better understanding of what you are experiencing.

BLADDER FUNCTION		
How many times do you urinate in the day? a. Up to 7 b. Between 8-10 c. Between 11-15 d. More than 15	How many times do you get up at night to urinate? a. 0-1 b. 2 times c. 3 times d. More than 3 times	Do you wet the bed before you wake up at night? a. Never b. Occasionally - less than once per week c. Frequently - once or more per week d. Always - every night
Do you need to rush or hurry to pass urine when you get the urge? a. Never - can hold on b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Does urine leak when you rush or hurry to the toilet. Can you make it in time? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Do you leak with squatting, sneezing, laughing or exercising? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily
Is your urinary stream weak, prolonged or slow? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Do you have a feeling of incomplete bladder emptying? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Do you need to strain to empty your bladder? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily
Do you have to wear pads because of urinary leakage? a. None - never b. As a precaution c. With exercise/during a cold d. Daily	Do you limit your fluid intake to decrease leakage? a. Never b. Before going out/socially c. Moderately d. Daily	Do you have frequent bladder infections? a. No b. 1 — 3 per year c. 4 — 12 per year d. More than once per month
Do you have pain in your bladder or urethra when you empty your bladder? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Does urine leakage affect your daily routine activities like recreation, socializing, sleeping, shopping, etc? a. Not at all b. Slightly c. Moderately d. Greatly	Other concerns:
BOWEL FUNCTION		
How often do you usually have a bowel movement? a. Every other day or daily b. Less than every 3 days c. Less than once a week d. More than once a day	What is the consistency of your stool like? a. Soft b. Hard/pebbles c. Watery d. Variable e. Firm	Do you have to strain a lot to empty your bowels? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily
Do you use laxatives to empty your bowels? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Do you feel constipated? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	When you get gas can you control it or does gas leak out? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily

Name:

Do you get an overwhelming sense of urgency to empty bowels? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Do you leak watery stool when you don't mean too? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Do you leak normal stool when you don't mean too? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily
Do you have a feeling of incomplete bowel emptying? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Do you ever use finger pressure to help empty your bowel? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Other concerns:
SUPPORTIVE STRUCTURES		
Do you have a sensation of tissue protrusion, lump or bulging in your vagina? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Do you experience vaginal pressure, heaviness or a dragging sensation? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	Do you have to push back your prolapse in order to void? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily
Do you have to push back your prolapse to empty your bowels? a. Never b. Occasionally - less than once per week c. Frequently - more than once per week d. Daily	How much of a bother is your prolapse to you? a. Not at all b. Slightly c. Moderately d. Greatly e. Not applicable	Other concerns:
SEXUAL FUNCTION		
Are you sexually active? a. No b. Less than once per week c. More than once per week d. Daily or most days	If you are not sexually active, please tell us why. a. Do not have a partner b. My partner is unable c. Vaginal Dryness d. Too Painful e. Embarrassment due to the prolapse or incontinence f. Other reasons	Do you have sufficient natural vaginal lubrication during intercourse? a. Yes b. No
During sexual intercourse, vaginal sensation is: a. Normal/pleasant b. Minimal c. Painful d. None	Do you feel that your vagina is too loose? a. Never b. Occasionally c. Frequently d. Always	Do you feel that your vagina is too tight? a. Never b. Occasionally c. Frequently d. Always
Do you experience pain with sexual intercourse? a. Never b. Occasionally c. Frequently d. Always	Where does the pain occur during sexual intercourse? a. No pain b. At the entrance to the vagina c. Deep inside/ in the pelvis d. Both at the entrance and in the pelvis	Do you leak urine during sexual intercourse? a. Never b. Occasionally c. Frequently d. Always the entrance and in the pelvis
How much do these sexual issues bother you? a. Not at all b. Slightly c. Moderately d. Greatly e. Not Applicable	Other concerns:	

Name:

LIFESTYLE HABITS

Do you have a trauma history? Yes or No (if yes, please explain)	
Do you experience stress? Yes or No	Currently my stress is: Mild Medium High
Do you know the cause?	
Where do you hold stress in your body?	
What do you do to reduce your stress?	
Do you relax or meditate? Yes or No	If yes, how often?
Do you exercise? Yes or No	If yes, how many times per week?
Please describe your routine:	

DESCRIBE A TYPICAL DAYS DIET:	
Breakfast:	Lunch:
Dinner:	Snack:
How many fruits and vegetables do you eat per day?	Any changes in appetite?
How much water do you drink per day?	How much coffee/tea/pop do you drink per day?
How many hours of sleep do you typically get?	Any difficulty: Falling Asleep/Staying Asleep/Waking from Pain

How many hours do you spend on screens per day? (includes smartphones, computer, tv)
How many hours do you sit per day?

What do you do in your life that brings you joy and pleasure?
Do you have a safe support system?

How much are you willing to commit to changing in order to get rid of the symptoms you are having? Whatever It Takes / Significant Change / Some Change / No Change
Anything else you would like us to know:
What are your goals for treatment?

Consent: I understand that I have been referred for pelvic floor physical therapy. To evaluate my condition, it may be necessary, to have my therapist perform an internal pelvic floor muscle exam. The exam and some treatments are performed by observing and/or palpating the perineal region including the vagina and/or rectum. This is never done without consent, you have the option to refuse and you are always welcome to have a third party attend for evaluation or treatments.

_____ _____

Signature Date

California Hand and Physical Therapy
Cancelation Policy

Dear Patients,

California Hand and Physical Therapy has an office policy for Late Cancelations and No show/Missed appointments.

Please provide our office with a 24 hour notice to change or cancel an appointment.

Answering machines are provided that you should use for after hours and on the weekends. 24 hour notice allows us to place another patient in your cancelled appointment period to receive needed treatment.

- If 3 or more appointments are missed consecutively at any time during a patient's treatment, any further appointments already scheduled will be taken off the schedule.

A **$50 fee** will be applied for your "No□Show" or "Non 24□Hour" cancellations, and this will **NOT** be covered by your insurance.

Our Therapist have set times and are unable to fill slots for patients in need of an appointment if little to no notice is given.

Thank you for your cooperation.

I have read and understood the above policy.

_____ _____

Patient Signature Date

_____ _____

Front Office/Staff Signature Date