**California Hand and Physical Therapy Pelvic Intake Form**

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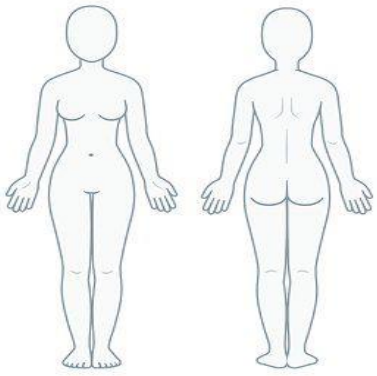
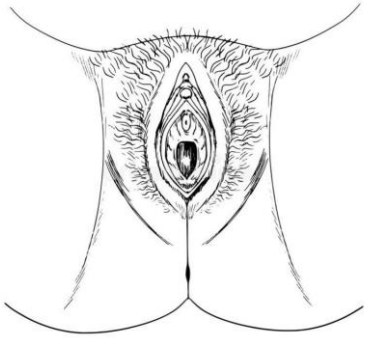
|---|---|---|
| Date:: | Referred By: | |
| Name: | Age: | DOB: |
| Address: | Cell #: | |
| City/State/Zip: | Email: | |
| Are you currently working? Yes or No | What is your occupation? | |
| Describe the symptoms that bring you to Pelvic Physical Therapy today? | | |
| When were these symptoms first noticed? | | |
| Please shade the areas that are bothering you:<br>   | | |
| 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)<br>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)<br>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<br>0 1 2 3 4 5 6 7 8 9 10 | Caretaking<br>0 1 2 3 4 5 6 7 8 9 10 |

| | |
|---|---|
| Sitting<br>0 1 2 3 4 5 6 7 8 9 10 | Household Chores<br>0 1 2 3 4 5 6 7 8 9 10 |
| Standing<br>0 1 2 3 4 5 6 7 8 9 10 | Work<br>0 1 2 3 4 5 6 7 8 9 10 |

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

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|---|
| 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 (ie: Birth Control, IUD):<br>If you have an IUD, what type is it: |
| 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 |

| | | |
|---|---|---|
| Dryness | Please describe your menstruation:<br>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** | | |
|---|---|---|
| Do you wet the bed? | N | Y |
| Have Burning/Pain With Urination | N | Y |
| Difficulty Starting A Stream Of Urine | N | Y |
| Do You Strain To Empty Your Bladder | N | Y |
| Feel Unable To Empty The Bladder Fully | N | Y |
| Have A "Falling Out" Feeling | N | Y |
| Have Urgency To Urinate | N | Y |
| Do You Urinate More Than 7 Times A Day | N | Y |
| Do You Use A Form Of Leakage Protection | N | Y<br>Adult pad: #___<br>Mini pad: #___<br>Liner: #___<br>Other _____ |
| Do You Restrict Your Fluid Intake | N | Y |
| **BOWEL FUNCTION** | | |
| Strain To Have A Bowel Movement | N | Y |
| Do You Include Fiber In Your Diet | N | Y |

| | | |
|---|---|---|
| Do You Take Laxatives/Enema Regularly | N | Y |
| Do You Have Pain With Bowel Movements | N | Y |
| Do You Leak/Stain Feces | N | Y |
| Do You Have Diarrhea Often | N | Y |

| **SEXUAL FUNCTION** | | |
|---|---|---|
| Are you sexually active?<br>a. No<br>b. Less than once per week<br>c. More than once per week<br>d. Daily or most days | If you are not sexually active, please tell us why.<br>a. Do not have a partner<br>b. My partner is unable<br>c. Vaginal Dryness<br>d. Too Painful<br>e. Embarrassment due to the prolapse or incontinence<br>f. Other reasons | Do you have sufficient natural vaginal lubrication during intercourse?<br>a. Yes<br>b. No |
| During sexual intercourse, vaginal sensation is:<br>a. Normal/pleasant<br>b. Minimal<br>c. Painful<br>d. None | Do you feel that your vagina is too loose?<br>a. Never<br>b. Occasionally<br>c. Frequently<br>d. Always | Do you feel that your vagina is too tight?<br>a. Never<br>b. Occasionally<br>c. Frequently<br>d. Always |
| Do you experience pain with sexual intercourse?<br>a. Never<br>b. Occasionally<br>c. Frequently<br>d. Always | Where does the pain occur during sexual intercourse?<br>a. No pain<br>b. At the entrance to the vagina<br>c. Deep inside/ in the pelvis<br>d. Both at the entrance and in the pelvis | Do you leak urine during sexual intercourse?<br>a. Never<br>b. Occasionally<br>c. Frequently<br>d. Always the entrance and in the pelvis |
| How much do these sexual issues bother you?<br>a. Not at all<br>b. Slightly<br>c. Moderately<br>d. Greatly<br>e. Not Applicable | Other concerns: | |

**LIFESTYLE HABITS**

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|---|---|
| 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 and treat 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