Name _____

Preferred Name (if different) _____

Pronouns
(she/her, he/him, them/they)
_____

Gender _____
Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Sex _____
This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Symptom Monitor

What brings you to pelvic floor physical therapy?

_____

_____

When or How did this start?

_____

What makes your symptoms or pain better?

_____

What makes your symptoms or pain worse?

_____

Have your pain/symptoms spread from its original problem?

_____

What do you think is causing your problem?

_____

What do you think needs to be done for your problem that has not been done already?

_____

Medical Health History

Please check off any of the following medical conditions that you currently have or have had in the past (add details in space below):

___ Unexpected weight loss or weight gain
___ Night sweats
___ Cancer or malignancy
___ Night pain
___ Heart Disease
___ Arthritis
___ Joint Replacement
___ Neck injury (including whiplash)
___ Osteoporosis or Osteopenia
___ Temporomandibular joint disorder (TMJ)
___ Diabetes
___ Thyroid problems
___ Autoimmune Disease
___ Chronic Fatigue
___ Fibromyalgia
___ Multiple chemical sensitivities
___ Overactive bladder
___ Irritable bowel syndrome
___ Endometriosis
___ Polycystic Ovarian Syndrome (PCOS)
___ Interstitial Cystitis
___ Bladder Pain Syndrome
___ Anxiety or panic attacks
___ Depression

Explanation:

_____

_____

Please list any additional medical issues, illness or diagnosis you are currently undergoing treatment or investigation for:

_____

Please list the medications you are currently taking (including vitamins and supplements), the dose and who prescribed it:

_____

Have you had any of the following medical procedures or treatments? If so, please provide the approximate date and relevant details.

___ Appendectomy
___ Bartholin Cyst
___ Bowel Resection
___ Laparoscopy
___ Cystoscopy
___ Hernia Repair
___ Hemorrhoid Surgery
___ Mesh Procedure
___ Prolapse/vaginal repair
___ Incontinence Surgery
___ Hysterectomy
___ Colostomy
___ Joint Surgery
___ Back Surgery
___ Neurosurgery
___ Cancer Treatments (Surgical, Chemotherapy or Radiation)
___ Immunosuppressant Therapy
___ Other _____

Gynecological History

Please leave anything blank that you are not comfortable answering.

What age did your period start? _____
Are you currently pregnant? _____
If so, how far along and estimated due date? _____

Please check off any of the following statements that applies to your menstrual cycle. Please provide relevant details

___ Pain inserting a tampon
___ Irregular menstrual cycle
___ PMS Symptoms
___ Pain/cramping with period
____ Low back pain with period
____ Heavy bleeding and/or flooding
____ Other _____

Please check all statements that apply to you for your current or past history of pap smear exams. Please provide relevant details

___ Pain with a pap exam _____
___ Inability to have a pap exam due to pain _____
____Treatment(s) for irregular pap exam _____

Are you currently on birth control? _____ If so, please describe _____

Have you gone through or are currently going through menopause? _____
Provide any relevant details _____

Please check off any symptoms or habits you have with respect to your vulva or vagina? Please provide relevant details.

___ Vulvar or vaginal or rectal itchiness
___ Vulvar or vaginal dryness
___ Vaginal pressure/heaviness
___ Unusual, odorous or itchy discharge
___ Feelings of something "falling out" of vagina

___ I feel like I have to "push something back in" to my vagina
___ I have been diagnosed with a prolapse (what type)
___ Scar pain from birth trauma
___ I wash my vulva/vagina out with soap or washes
___ I use(d) oral or cream-based hormonal replacement therapy
___ I use a vaginal moisturizer
___ Other _____

Have you had any other gynecological treatments, investigations, or procedures? If yes please describe

_____

Are you currently seeing, or are you regularly followed, by a gynecologist? If yes please describe

_____

Sexual Health and Pain History

Please complete the following sections only as it applies to you and you feel comfortable to do so. Please leave any questions blank that you are uncomfortable answering

Are you sexually active? _____ If No, please skip all the following questions in these section.
Do you have pain during or after intercourse? ____ If yes please describe _____
How was your first sexual experience? Positive _____ Negative _____
Do you use lubricant? _____ If yes, please describe _____
Do you have any fears, worries, or concerns about intercourse? _____
Have you ever had an unwanted sexual experience, touch or abuse? _____

Pregnancy and/or Childbirth History

Please complete the following sections only as it applies to you and you feel comfortable to do so. Please leave any questions blank that you are uncomfortable answering

Not Applicable to me - Please skip to the next section
Number of Pregnancies _____
Number of Live Birth(s) _____
Age of Living Children _____
Weight of heaviest baby? _____
Longest pushing stage? _____

Have you ever had any of the following? If yes, please describe relevant information or medical procedures.
Miscarriage ____
Abortion ____
Stillborn Child ____

Type of Delivery - Please add how many of each type of delivery you have had beside it
Vaginal Delivery _____
Planned C-section _____
Emergency C-section _____

In your birth(s), did you have any of the following? If yes, please describe
___ Forceps
___ Vacuum
___ Manual-assisted delivery
___ Tear or Episiotomy
(please list the Grade (1-4) if known
___ Pain Remaining at the scar site after birth
___ Poor healing after birth
___ Infections after birth
___ Other issues after birth _____
_____

During my labor(s) and delivery, I felt supported and cared for (please describe if relevant):
___ All or most of the time _____
___ Some of the time _____
___ A little bit _____
___ Not at all _____

Were there times when the baby was or seemed to be in danger during labor & delivery? If yes, please describe _____

Were there times during labor and delivery that you were (or thought you were) in danger of death or injury? If yes, please describe _____

Do you currently or have you in the past, struggled with Post-Partum Depression? If yes, please describe _____

Do you currently experience any trauma, fear, negative flashbacks, or anger about your delivery? If yes, please describe _____

Is there anything else about your labor(s), delivery, or post-partum healing phase we should know?

Do you feel you still have long term effects from your labor, delivery or pregnancy? If yes, please describe _____

Bladder Health History

Please complete the following sections only as it applies to you and you feel comfortable to do so. Please leave any questions blank that you are uncomfortable answering

___ Urinary Tract Infections
If so, how often and when was your last UTI? _____
___ Yeast infections
If so, how often and when was your last yeast infection? _____
___ Blood in your urine

Please check off all that apply to you regarding bladder leakage and voiding. If yes, please provide relevant details
___ Leakage/incontinence with sneezing, coughing, running, jumping, laughing or exercises
___ Leakage during intercourse _____
___ Really strong, urgent bladder sensations prior to voiding _____
___ Leakage that occurs after having a strong bladder urge that feels uncontrollable _____
___ Leakage during everyday activities _____
___ My bladder leaks and I do not notice it (passive leakage) _____
___ Leakage overnight while I am sleeping _____
___ Leakage as I stand up from the toilet _____
___ I wear pads for my incontinence (how often and what type) _____
___ Other _____

Please check any of the following statements in relation to your bladder voiding/emptying habits. If yes, please provide relevant details
___ Bladder pain/burning/sensitivity _____
___ Pain when my bladder fills up _____
___ Bladder pain improves when I empty my bladder _____
___ Bladder does not empty fully each time I void _____

___ Have to strain/push to empty my bladder fully _____
___ Have to empty my bladder again shortly after I have just emptied it _____
___ Difficulty starting my urine stream _____
___ Sometimes hover above toilets to void _____
___ Often rush going through the bathroom because of time/business/etc _____
___ Get up to void at night (how many times) _____
___ Other _____

Please check off what you drink in a day and how much of each:
___ Coffee - caffeinated (cups/day)
___ Tea - caffeinated (cups/day)
___ Other fluids - including decaf coffee and tea (cups/day)
___ Alcoholic drinks (in day/week or month)

Bowel and Digestive Health

Please complete the following sections only as it applies to you and you feel comfortable to do so. Please leave any questions blank that you are uncomfortable answering.

Please check all statements that apply to how your bowel movements happen, please provide details as necessary.
___ I have blood in my stool
___ I have rectal bleeding and/or black, tarry stool
___ I have at least one bowel movement every day
___ My bowel movements are quick and easy to pass
___ I struggle with constipation
___ I struggle with diarrhea or loose stools
___ I DO NOT have a bowel movement every day
___ I have hard, lumpy stools
___ I have to strain/push to have a bowel movement
___ I feel like I do not empty my bowel completely after bowel movements
___ I have to splint or assist to pass stool (either vaginally or rectally)
___ I feel like I have a bowel blockage or obstruction
___ It takes me longer than 5 minutes to have a bowel movement
___ I regularly use laxatives, stool softeners or enemas (please describe routine)
___ I have had a significant change to my bowel or abdominal health recently

Please check all statements that apply to how your bowel movements and gas feel, provide extra detail as needed:
___ Bowel movements are urgent and difficult to control _____
___ Lose control of stool accidentally or incontinence of stool _____
___ Cannot control gas and will loose it accidentally _____
___ Pain DURING a bowel movement _____
___ Pain BEFORE a bowel movement _____
___ Pain AFTER a bowel movement _____
___ Other _____

Please check all statements that apply to your digestive and abdominal health, provide additional details when possible.
___ Bloating
___ Abdominal pain
___ Physical change in abdominal girth when bowels are full
___ Digestive issues

___ Food sensitivities
___ Irritable Bowel Syndrome
___ Ulcerative colitis
___ Celiac Disease
___ Other _____

Social History

Please complete the following sections only as it applies to you and you feel comfortable to do so. Please leave any questions blank that you are uncomfortable answering.

What do you do for fun or leisure?

Do your symptoms impact your fun or leisure activities?

_____

Who lives in your home with you?

_____

Who supports you with your pain and/or symptoms?

_____

Tell us about your job/work, and does your pain/symptoms affect your job/work?

_____

Have you ever been for counseling? If yes, was it helpful?

_____

On a scale of 1-10 with 10 being the most bothersome, please rate how bothersome this problem is for you

0 1 2 3 4 5 6 7 8 9 10

On a scale from 1-10 with 10 being the most hopeful, please circle and rate how hopeful you are that you will be able to correct this problem

0 1 2 3 4 5 6 7 8 9 10

Childhood traumatic experiences are linked to adult chronic disease such as heart disease, cancer, diabetes and persistent pain. The following questions will give you your ACE score. Research shows that when people have had an opportunity to talk about adverse childhood experiences, the link to health problems is reduced. Please check off any of the following childhood events. Please answer only within your comfort zone which events you experienced as a child.

___ Were you physically abused as a child? _____
___ Were you touched sexually against your will as a child? _____
___ Were you emotionally abused as a child? _____
___ Did you experience physical neglect as a child? _____
___ Were your parents divorced when you were a child? _____
___ Did you experience emotional neglect as a child? _____
___ Did anyone in your house have mental illness as a child? _____
___ Was your mother treated violently when you were a child? _____
___ Did you have an incarcerated relative when you were a child? _____
___ Was there substance abuse in your household as a child? _____

Accuracy of Information

I certify that the above medical information is correct to my knowledge.

_____ _____

Signature Date