Pelvic Physiotherapy Initial Intake Form

The information you are about to provide is for your benefit and protection.
It is for the private use of this office (unless you sign a release form)
to aid your Physiotherapist in gaining a better understanding of your condition.

Name: _____ Date: _____

Presenting Problems
What are your presenting problems?

_____

When did this start? _____

General Questions
What are some hobbies/ activities you do on a regular basis? _____

What are your goals for physiotherapy? _____

Gynecological History- **please complete the following section as it applies to you.**
At what age did your period start? _____

Is your cycle regular? Yes ☐ No ☐

How long is your cycle? _____

Do you experience PMS? Yes ☐ No ☐

Do you have heavy bleeding? Yes ☐ No ☐

Do you have pain with your period? Yes ☐ No ☐

If yes, when? And how? _____

Do you use tampons? Yes ☐ No ☐

If yes, do you have pain with insertion? Yes ☐ No ☐

Do you have excessive discharge? Yes ☐ No ☐

Are you sexually active? Yes ☐ No ☐

Do you take birth control? Yes ☐ No ☐

If yes, what type? _____

Pelvic initial intake form continued…

Do you experience pain with intercourse? Yes ☐ No ☐

Do you use lubrication? Yes ☐ No ☐

If yes, what? _____

Number of pregnancies: _____ Number of live births: _____

Weight of heaviest baby: _____ Length of pushing stage of heaviest baby: _____

Number of C-sections: _____ Number of vaginal deliveries: _____

Birth-related Questions- **please complete the following section if it applies to you.**

Did you have an epidural? Yes ☐ No ☐

Did you have a vacuum-assisted delivery? Yes ☐ No ☐

Were forceps used? Yes ☐ No ☐

Did you have an episiotomy? Yes ☐ No ☐

Did you have any tearing? Yes ☐ No ☐

Were there times during labour/delivery you were (or thought you were) in danger? Yes ☐ No ☐

Were there times the baby was (or was thought to be) in danger? Yes ☐ No ☐

Do you suffer/ have you suffered from post-partum depression? Yes ☐ No ☐

Have you gone through menopause? Yes ☐ No ☐

Do you experience vaginal dryness? Yes ☐ No ☐

Are you undergoing any hormone therapy? Yes ☐ No ☐

If yes, what? _____

Do you have feelings of heaviness/ pressure in your vagina? Yes ☐ No ☐

Have you ever been told you have a prolapse? Yes ☐ No ☐

Prostate/Penile Health- **please complete the following section as it applies to you.**

When was your last PSA? _____

Last PSA score: _____

When was your last digital rectal exam? _____

Pelvic initial intake form continued…

Does your prostate get painful/ irritated? Yes ☐ No ☐

Has your prostate fluid been tested? Yes ☐ No ☐

Do you have painful erections? Yes ☐ No ☐

Can you achieve a satisfactory erection? Yes ☐ No ☐

Do you have premature ejaculation? Yes ☐ No ☐

Do you have pain during intercourse? Yes ☐ No ☐

If yes, when? _____

Medical Procedure History- please check any that apply and add the approximate date below.

Appendectomy ☐	Bartholin Cyst ☐	Bowel resection ☐	Laparoscopy ☐	Cystoscopy ☐
Colonoscopy ☐	TVT-TVT (o) ☐	Gallbladder removal ☐	Hemorrhoid surgery ☐	Mesh procedure ☐
Prolapse repair ☐	Hysterectomy ☐	Colostomy ☐	Vasectomy ☐	Prostatectomy ☐
Hernia repair ☐	Urodynamic ☐	Other:		

Bladder Symptoms- please complete the following section as it applies to you.

Did you have problems with your bladder in childhood? Yes ☐ No ☐ Sometimes ☐

Do you have leakage associated with sneezing, coughing, running and/ or laughing? Yes ☐ No ☐ Sometimes ☐

Do you have leakage during intercourse? Yes ☐ No ☐ Sometimes ☐

Do you feel really strong sensations prior to voiding but don't leak? Yes ☐ No ☐ Sometimes ☐

Does your leakage occur after have a strong urge that feels uncontrollable? Yes ☐ No ☐ Sometimes ☐

Do you have pain when your bladder fills? Yes ☐ No ☐ Sometimes ☐

Do you have pain when you void? Yes ☐ No ☐ Sometimes ☐

Does your pain improve when you void? Yes ☐ No ☐ Sometimes ☐

Do you have to strain to empty your bladder? Yes ☐ No ☐ Sometimes ☐

Do you difficulty starting your urine stream? Yes ☐ No ☐ Sometimes ☐

Do you have dribbling after your get up from the toilet? Yes ☐ No ☐ Sometimes ☐

Pelvic initial intake form continued…

Do you sit on the toilet? Yes ☐ No ☐ Sometimes ☐

Do you have incomplete emptying when you void and feel like you have to go again? Yes ☐ No ☐ Sometimes ☐

Do your bladder problems cause you to leak at night? Yes ☐ No ☐ Sometimes ☐

Does your incontinence fluctuate with your cycle? Yes ☐ No ☐ Sometimes ☐

Does your incontinence require you to wear pads? Yes ☐ No ☐ Sometimes ☐

Do you void during the day more than 5-7x a day? Yes ☐ No ☐ Sometimes ☐

If yes or sometimes, how often? _____

Do you need to get up at night to void? Yes ☐ No ☐ Sometimes ☐

If yes or sometimes, how often? _____

Fluid Intake in 24 Hours
How many cups of each do you have per day?

Water: _____ Coffee: _____

Tea: _____ Other: _____

Alcohol: _____

Digestion and Bowel Function- **Please answer the following questions as it applies to you.**

What is the frequency of your bowel movements? _____times a day _____times a week

Do you regularly feel the urge to move your bowels? Always ☐ Rarely ☐ Never ☐

Do you have constipation? Always ☐ Rarely ☐ Never ☐

Do you strain to have a bowel movement? Always ☐ Rarely ☐ Never ☐

Do you have loose stool/ diarrhea? Always ☐ Rarely ☐ Never ☐

Do you have bowel urgency that is difficult to control? Always ☐ Rarely ☐ Never ☐

Do you lose control of your bowels? Always ☐ Rarely ☐ Never ☐

Do you have incomplete emptying? Always ☐ Rarely ☐ Never ☐

Do you have pain WITH a bowel movement? Always ☐ Rarely ☐ Never ☐

Do you have pain AFTER a bowel movement? Always ☐ Rarely ☐ Never ☐

Does it take longer than 5 minutes to have a bowel movement? Always ☐ Rarely ☐ Never ☐

Pelvic initial intake form continued…

Do you have bloating? (increased pressure in your abdomen) Always ☐ Rarely ☐ Never ☐

Do you experience a physical change in abdominal girth when your bowels are full? (distention) Always ☐ Rarely ☐ Never ☐

How is your fibre intake? Too Low ☐ Adequate ☐ Too high ☐

Do you regularly use: Laxatives ☐ Stool Softeners ☐ Natural products ☐ Enemas ☐

Have you ever been diagnosed with/ think you have:

☐ Irritable Bowel Syndrome ☐ Ulcerative Colitis ☐ Chron's Disease ☐ Celiac Disease

Medical History- **Please answer the following questions to the best of your abilities, as it applies to you.**

Do you get urinary tract infections? Yes ☐ No ☐

If yes, how often? _____

When was your last UTI? _____

Do you have any food allergies/ sensitivities? Yes ☐ No ☐

Have you taken antibiotics recently? Yes ☐ No ☐

If yes, how often? _____

Do you take any probiotics? Yes ☐ No ☐

If yes, what is it? _____

Do you smoke? Yes ☐ No ☐

If yes, how many packs per day? _____

Do you have a chronic cough? Yes ☐ No ☐

Do you get yeast infections? Yes ☐ No ☐

If yes, how often? _____

What treatment did you use? _____

Do you get blood in your urine? Yes ☐ No ☐

Do you exercise? Yes ☐ No ☐

If yes, what type and what frequency? _____

Do you experience low back pain? Yes ☐ No ☐

Pelvic initial intake form continued…

Do you experience mid back problems? Yes ☐ No ☐

Do you have neck problems? Yes ☐ No ☐

Are any of those conditions chronic? Yes ☐ No ☐

If yes, what? _____

Have you ever been treated for depression? Yes ☐ No ☐

If so, what treatment? _____

Is/ was the treatment effective? Yes ☐ No ☐

Have you ever been treated for anxiety? Yes ☐ No ☐

If so, what treatment? _____

Is/ was the treatment effective? Yes ☐ No ☐

Have you ever been diagnosed with a mental health condition? Yes ☐ No ☐

If yes, what? _____

On a scale of 1-10, please rate how much the current **presenting problem** bothers you by circling a number below:

1- no pain 10- severe pain

1	2	3	4	5	6	7	8	9	10

On a scale of 1-10, please rate how motivated you are to correct the **presenting problem** by circling a number below:

1- not motivated 10- very motivated

1	2	3	4	5	6	7	8	9	10