Pelvic Intake Form

Date:_____________ Name:____ DOB:__________________

FIRST MI LAST

Pronouns:_____________ Gender:__________________ Gender assigned at birth:_____________________

Reason you are seeking PT treatment:____

Bladder Function

How many times do you typically urinate during the day?__________________________________

How many times do you need to wake up from sleeping to urinate?_________________________

Do you lose urine? Circle one - YES / NO If Yes, check all that apply below

- ☐ Coughing/Laughing/Sneezing
- ☐ Lifting / Exercising / Jumping /change position
- ☐ Arriving home
- ☐ Hearing running water
- ☐ With intercourse
- ☐ Waiting too long
- ☐ At night while sleeping
- ☐ Just after emptying bladder
- ☐ With a strong urge to urinate
- ☐ Do not lose urine
- ☐ Other:____

Do you need to wear pads due to urinary leakage? **Circle one - YES / NO**

If Yes, What type? How many/day?____

Do you have pain or difficulty with (check all that apply below)

- ☐ Frequent urination
- ☐ Emptying bladder completely
- ☐ Difficulty starting urine stream
- ☐ A change in urinary flow
- ☐ Pain with a full bladder
- ☐ Blood in urine
- ☐ After eating or drinking certain foods/beverages
- ☐ Strong urges to urinate
- ☐ Pain or burning with emptying your bladder
- ☐ Frequent Bladder Infections/UTI
- ☐ Other:____

Do you have a history of bladder infections? **Circle one- YES / NO**

If Yes, please specify: ____

Any recent urine or bladder testing performed? **Circle one- YES / NO**

If Yes, please specify: ____

Any bladder surgeries? **Circle one- YES / NO**

If Yes, please specify: ____

Do you take any medications or supplements for your bladder health? **Circle one- YES / NO**

If Yes, please list:____

Bowel Function

How often do you have a bowel movement? ______________________________________

What is the typical consistency (check all that apply)

☐ Loose ☐ Pellets ☐ Formed ☐ Hard

Do you lose stool or gas? Circle one - YES / NO If Yes, check all that apply below

☐ With strong urge to have a BM
☐ only when stool is loose
☐ with cough, laugh, sneeze
☐ after eating or drinking certain foods
☐ with exercise / change of position
☐ Do not loose stool or gas

Do you need to wear pads due to bowel leakage? **Circle one- YES / NO**
If yes, How many /day?____

Do you have pain or difficulty with bowel movements? (check all that apply)

☐ Constipation
☐ Bloating
☐ Bleeding with passing stool
☐ Pain/Cramping before or after passing stool
☐ Straining or difficulty getting stool out
☐ Anal/Rectal pain
☐ Anal itching
☐ Fecal stains on underwear
☐ Feeling of incomplete bowel movements
☐ Do not have pain

Do you take any medications or supplements to help manage bowel symptoms? **Circle one- YES / NO**
If yes, Please list____

Do you currently or have a history of anal fissure or hemorrhoids? **Circle one- YES / NO**

Any bowel or colorectal surgeries? **Circle one- YES / NO**
If Yes, please specify: ____

Any recent tests regarding bowel function? **Circle one- YES / NO**
If Yes, please specify: ____

Sexual Function

Are you currently sexually active? **Circle one- YES / NO**

Do you have any pain with sexual activity? **Circle one- YES / NO**
If yes, where?____

Do you have pain or problems with arousal? **Circle one- YES / NO**

Are you able to achieve orgasm? **Circle one- YES / NO**

Do you take any medications, supplements, or use lubricants for sexual health? **Circle one- YES / NO**

Do you use a form of birth control? **Circle One- YES / NO**
If yes, what?____

Do you currently or have a history of sexually transmitted disease? **Circle one- YES / NO**

Are you currently experiencing or have a history of sexual abuse/ trauma? **Circle one- YES / NO**

Pelvic Function

Do you ever have the sensation of pressure / pain in the low abdomen or perineum? **Circle one- YES / NO**

Do you feel like a pelvic organ is falling out? **Circle one- YES / NO**
If yes, please specify certain activities that make this worse?
____

Do you have or have history of any injuries to **(check all that apply)**

- ☐ Pelvic bones
- ☐ Pubic symphysis joint
- ☐ Sacrum
- ☐ SI joints
- ☐ Tail bone
- ☐ Low back or hips
- ☐ N/A

If any are selected, please explain:
____
____

Have you had any abdominal, pelvic, back or hip surgeries? **Circle one- YES/NO**
If Yes, please specify: ____

Have you recently had a vaginal or rectal pelvic exam? **Circle one- YES/NO**
If yes, Results:____

Have you had any other testing or imaging for your pelvis, back or hips? **Circle one- YES/NO**
If Yes, please specify: ____

OB/GYN HISTORY: ☐ N/A

If N/A is not selected, please answer questions below

Have you ever been pregnant? **Circle one- YES/NO**
If yes:

Pregnancies_____ # Vaginal Deliveries______ # C-Section Deliveries_____

Episiotomies? **Circle one- YES/NO** Instrumentation required for delivery of a baby? **Circle one- YES/NO**
If yes, please specify: ____

Any complications with pregnancy, deliveries, post-partum? **Circle one- YES/NO**
If yes, please explain:____

Do you have periods? **Circle one- YES/NO** Are you currently breastfeeding? **Circle one- YES/NO**

Any complications with menstrual cycles? **Circle one- YES/NO**

If yes, please explain:____

Are you experiencing symptoms associated with Perimenopause or Menopause? **Circle one- YES/NO**

If yes, please specify:____

Are you taking any medications or supplements to assist with menstrual cycles, reproductive health, pregnancy, menopause, etc? **Circle one- YES/NO**

If yes, please list:____