PELVIC HEALTH INTAKE FORM

Name: _____ Date of Birth: _____ Today's Date: _____

Preferred Phone: (____) _____ - _____ Home / Cell Gender: _____ Pronoun: She/Her / He/Him / They/Them

Email Address: _____ @ _____ Best way to contact: ☐ Call ☐ Text ☐ Email

Emergency Contact: _____ Relationship: _____ Phone Number: (____) _____ - _____

How did you choose HonorHealth Outpatient Therapy? (Check one) ☐ Physician Recommended

☐ Previous Patient ☐ Friend/Family Recommended ☐ Internet/Website _____

Referring Physician: _____ Primary Care Physician: _____

Do you have a follow-up appointment with your referring physician? ☐ Y ☐ N Date: _____

Chief Complaint: _____

_____

_____

Date of Onset of Symptoms: _____

Have you had Physical Therapy for this current issue before? ☐ Y ☐ N
If Yes, when and where: _____

Have you had previous abdominal or pelvic surgeries? ☐ Y ☐ N Type: _____

Have you had any Surgery? ☐ Y ☐ N

If yes, date/type of surgery: _____

Have you had (Check All that Apply):

☐ X-rays	Results: _____	Date: _____
☐ CT Scan	Results: _____	Date: _____
☐ MRI	Results: _____	Date: _____
☐ Ultrasound	Results: _____	Date: _____
☐ Urodynamics	Results: _____	Date: _____
☐ Cystoscopy	Results: _____	Date: _____
☐ Urine test (UA, culture, other)	Results: _____	Date: _____
☐ Colonoscopy/Other	Results: _____	Date: _____

Please rate your General Health: (Check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any medications or supplements you are taking to manage either your pain, urinary, and/or bowel symptoms:

_____

_____

_____

Are you currently sexually active? ☐ Y ☐ N
Do you currently have, or have a history of, sexually transmitted diseases? ☐ Y ☐ N
If yes, please explain and list any medications related:

_____

Please check all that apply

Pregnancy History

Are you pregnant, trying to become pregnant, or currently breastfeeding? ☐ Y ☐ N

Number of pregnancies: _____ Number of deliveries: Vaginal:_____ Cesarean:_____ Episiotomies:_____

Have you had complications related to pregnancy or delivery? ☐ Y ☐ N

PAIN

Do you have pain with:

☐ Sexual intercourse ☐ During ☐ After: Immediately Hours/days_____

☐ Orgasm/ejaculation/masturbation

☐ Pelvic exam

☐ Tampon use

☐ Clitoral/penile stimulation

☐ Abdominal pain

☐ Pain in perineum (area between rectum and vagina/scrotum)

☐ Pain in (circle any that apply): Low back Sacrum Hips Tailbone Groin

BLADDER

Do you lose urine when you:

☐ Cough/sneeze/laugh ☐ Lift/exercise/dance/jump

☐ On the way to the bathroom ☐ Strong urge to urinate

☐ Hear running water ☐ Lie down or Sleep

☐ Wear a protective undergarment or pad for incontinence? Number of changes in 24 hr period: _____

☐ Pain or burning during or after urination ☐ Pain with a full bladder

☐ Hesitancy starting urine stream ☐ Strain/Push to empty bladder

☐ Feeling of incomplete bladder emptying ☐ Low urine volume/weak flow

☐ Strong sense of urgency to urinate

☐ How often do you urinate during the day from waking until bed? _____

☐ How often do you get up to urinate at night? _____

☐ Do you have frequent urinary tract infections or the *feeling* of an infection? Number in past year: _____

BOWEL

☐ Constipation ☐ Take laxatives / enema regularly

☐ Strain/push to have a bowel movement ☐ Include fiber supplements in your diet

☐ Diarrhea ☐ Leak gas by accident

☐ Fecal Staining or Leaking ☐ Activities associated with fecal leaking: _____

☐ Pain with bowel movement ☐ Strong sense of urgency to have bowel movement

How many often do you move your bowels: _____ per day / week

Most common stool consistency

____ liquid ____ soft ____ firm ____pellets ____ other_____

What are the main goals you would like to achieve through physical therapy?

_____

Do you have a history of sexual abuse or trauma that you would like your therapist to be aware of? Y N

Patient's Signature:_____ Date:_____

Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, **how much they bother you.** Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptom scale:

0 = not present
1= not at all
2 = somewhat
3 = moderately
4 = quite a bit

Pelvic Organ prolapse Distress Inventory 6 (POPDI-6)

Do You...	NO	YES
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal distress Inventory 8 (CRAD-8)

Do You...	NO	YES
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary distress Inventory 6 (UDI-6)

Do You...	NO	YES
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Female NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

Center for Urologic and Pelvic Pain

Name: _____ **Date:** _____

Pain or Discomfort

		Yes	No
1.	In the last week, have you experienced any pain or discomfort in the following areas?		
	a. Area between rectum and vagina (perineum)	1	0
	b. Labia	1	0
	c. Clitoris (not related to urination)	1	0
	d. Below your waist, in your pubic or bladder area	1	0
	e. Below your waist, in your rectal area	1	0

		Yes	No
2.	In the last week, have you experienced:		
	a. Pain or burning during urination?	1	0
	b. Pain or discomfort during or after sexual climax?	1	0

3. How often have you had pain or discomfort in any of these areas over the last week?

   0 Never **1** Rarely **2** Sometimes **3** Often **4** Usually **5** Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

   0 1 2 3 4 5 6 7 8 9 10

   no pain — pain as bad as you can imagine

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

   0 Not at all **2** Less than half the time **4** More than half the time
   1 Less than 1 time in 5 **3** About half the time **5** Almost always or always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

   0 Not at all **2** Less than half the time **4** More than half the time
   1 Less than 1 time in 5 **3** About half the time **5** Almost always or always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

   0 None **1** Only a little **2** Some **3** A lot

8. How much did you think about your symptoms, over the last week?

   0 None **1** Only a little **2** Some **3** A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

   0 Delighted **1** Pleased **2** Mostly satisfied **3** Mixed (about equally satisfied and dissatisfied) **4** Mostly dissatisfied **5** Unhappy **6** Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c, 1d, 1e, 2a, 2b, 3 and 4 _____

Urinary Symptoms: Total of items 5 and 6 _____

Quality of Life & Impact: Total of items 7, 8 and 9 _____