SW PHYSICAL THERAPY

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Pelvic Intake

Name _____ Today's Date _____
Occupation _____ Are you currently off work because of this problem? ☐Yes ☐No☐ Light Duty
When did your problems begin? _____
How did problems begin? _____
_____

Please check any that apply to you:
☐Urinary incontinence ☐Prolapse
☐Urgency ☐Increased frequency ☐ Pain
☐Numbness/ Tingling
☐Other _____

Rate your pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Is your pain constant? ☐Yes ☐No
Intermittent? ☐Yes ☐No

Have you had any previous treatment or testing for your current condition? ☐Yes ☐No
If yes, please describe: _____

Are you currently being treated by any other physical medicine providers? Ex: Chiropractor, Acupuncture or Physical Therapist

_____

If so when did this take place? Where? _____

Any medical problems? ☐Yes ☐No
If yes, please explain: _____
_____

Please list ALL medications you are currently taking, prescription and over-the-counter, for this and any other conditions (If being seen by a non SW Family provider): _____
_____

Have you ever had a history of any of the following? ☐Major injury to the head/ spine ☐Cancer/ Tumors ☐Osteoporosis ☐Dizziness/ Blackouts ☐Heart problems/ Angina ☐Diabetes ☐Pacemaker ☐Sudden weight loss/ gain ☐Severe pain at night
☐Smoking ☐Bruising easily ☐Asthma ☐Frequent falls ☐Loss of bowel/ bladder control ☐Numbness
☐Seizures/ Epilepsy ☐High blood pressure ☐ Coordination loss

OB/Gynecological history:

Are you currently pregnant? Y N

Number of Pregnancies _____

Number of Births: _____ Vaginal _____ Cesarean Section _____

Complications:(circle what applies) : Baby >8 lbs Use of Forceps Episiotomy Other

What is your marital status? _____
Are you currently sexually active? Y N
Do you have any STIs? Y N
History of sexual abuse or trauma? Y N

Menstrual history:
What was the date of your last period? _____
Have you gone through menopause? Y N
Use of hormone replacement? Y N

Bladder symptoms

How many times do you urinate during the day? _____ night? _____

How often do you leak? (Mark what applies)

1x/week	2-3x/week	1x/day
Several times a day	All of the time	

When you leak, is it a **small**, **moderate** or **large** amount? (Please circle)

When you leak what is the cause? (Mark all that apply)

exercise/lift/dance/jump	cough/sneeze/laugh	other
on the way to the bathroom	intercourse	for no reason

On a scale of 0-10 (with 0 being none and 10 being the most), how much does leaking urine interfere with your everyday life?

0 1 2 3 4 5 6 7 8 9 10

Do you have pain with urination? Y N
Do you have difficulty starting to urinate? Y N
Do you strain to empty your bladder? Y N
Do you get frequent bladder infections? Y N
Do you feel a heaviness or pressure in your pelvic region? Y N

What are Your goals for Physical Therapy?

_____

Thank you for taking the time to fill out this questionnaire.

I understand that the information I have provided will be held in the strictest confidence and that I have the right to view my records upon written request. I further understand that the Physical Therapy I receive is provided for the purpose to help me heal and achieve my goals.