PATIENT HISTORY - PELVIC PHYSICAL THERAPY

Name: _____ **Date:**_____

1. What current problem/condition are you seeking physical therapy for?

2. When did your problem first begin and how? If a long time ago, did it recently get worse?

3. If pain is present, rate pain on a 0-10 scale (10 being the worst)
   Current pain _____
   Worst in last 48 hours _____
   Best in last 48 hours _____

Describe the nature of the pain (i.e. constant/intermittent, burning, ache, sharp, shooting)

4. What other therapies or treatments have you tried? Did they help?

5. Which of the following activities worsen your symptoms. Check all that apply.

- ☐ Sitting greater than_____ minutes
- ☐ Walking greater than _____minutes
- ☐ Standing greater than _____ minutes
- ☐ Moving from sit to stand
- ☐ Moving from lying to sitting
- ☐ Light activity (light housework)
- ☐ Nervousness/anxiety
- ☐ Emptying bladder
- ☐ Activity does not worsen this issue
- ☐ Other, please list _____

- ☐ Cough/sneeze/strain
- ☐ Exercise
- ☐ Lifting
- ☐ Bending
- ☐ Cold weather
- ☐ Running water
- ☐ Sexual activity
- ☐ Having a bowel movement

6. What makes your symptoms feel better?

7. How do the symptoms affect your life? (What would you be able to do if you did not have this issue?) Consider social activities, fitness, work, hobbies, sexual health etc.

8. What are your treatment goals/concerns?

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MEDICAL HISTORY

Have you had blood in your stool or urine? Y / N

Do you have any implanted devices? Y / N

Do you take blood thinning medication? Y / N

What testing has been completed for your current complaints?

How would you describe your current stress level? High Medium Low

Do you have a counselor or psychologist? Yes No

Indicate if you have had or currently have any of the following:

Y / N	Endometriosis	Y / N	Polycystic ovarian syndrome
Y / N	Menopausal symptoms	Y / N	Uterine cysts
Y / N	Heavy or excess menstrual flow	Y / N	Ovarian cysts
Y / N	History of childhood urinary issues	Y / N	Prolapse
Y / N	Painful vaginal penetration	Y / N	Difficulty with orgasm
Y / N	Vaginal dryness	Y / N	Painful menstruation
Y / N	Pelvic pain	Y / N	Hypothyroid/ Hyperthyroid
Y / N	Physical or Sexual abuse	Y / N	Low back pain
Y / N	Sexually transmitted disease	Y / N	Sacroiliac/Tailbone pain
Y / N	HIV/AIDS	Y / N	Hip pain
Y / N	Hepatitis	Y / N	Irritable Bowel Syndrome
Y / N	Latex sensitivity	Y / N	Anorexia/bulimia
Y / N	Kidney disease	Y / N	Raynaud's (cold hands and feet)
Y / N	Emphysema/chronic bronchitis	Y / N	Chronic Fatigue Syndrome

When was the date of your last gynecological exam? _____

Are you pregnant, possibly pregnant or trying to get pregnant? Y / N

Are you currently on birth control? Y / N If yes, what kind? _____

Number of pregnancies ____ Number of live births ____ Number of miscarriages ____

Did you have difficulty with childbirth or with pregnancy? Y / N
If yes, please describe:

Did you have c-section, vaginal birth or vaginal birth after c-section?

Did you have any episiotomies? Y / N

Did you have any perineal tearing? Y / N If yes, what degree/stage? _____

Are you menopausal? Y / N If yes, are you on hormone replacement therapy? Y / N

BOWEL SYMPTOMS

Do you have a daily, pain-free bowel movement (BM)? Y / N

Do you have a sense of incomplete emptying after BM? Y / N

Do you have pain with the urge to have a BM? Y / N

Do you have pain with passing a BM? Y / N

Do you have bleeding with a BM? Y / N

Do you strain to have a BM? Y / N

Do you spend more than 10 minutes on a toilet at a time? Y / N

Do you currently use laxatives? Y / N

Do you have difficulty holding back gas? Y / N

Do you experience bowel leakage? Y / N

If bowel leakage, how often? _____

If bowel leakage, what amount? (small or large) _____

How long can you delay emptying with bowel urge? _____

How many times per week do you have a BM? _____

BLADDER SYMPTOMS

How often during the day do you empty your bladder (void)? _____

How many times do you wake at night to empty your bladder? _____

How long can you wait to void when you get an urge? _____

Do you usually pass small, medium or large amounts of urine? _____

Do you have difficulty starting the flow of urine? Y / N

Do you have intermittent stream of urine? Y / N

Can you stop the flow of urine if you try? Y / N

Does your bladder feel empty after you void? Y / N

Do you strain, push or bear down to void? Y / N

Do you dribble after you void? Y / N

Does it hurt to empty your bladder? Y / N

Do you empty your bladder to ease pain? Y / N

Can you tell when your bladder is full? Y / N

Do you experience leakage of urine? Y / N

If yes to leakage, how much urine? (small or large) _____

What kind of leakage protection do you use? (pad, diaper, liner etc) _____

How many pads or diapers do you use in a 24 hour period? _____

During what activities do you leak? (sleep, exercise, sex, etc) _____

If an average cup is 8 ounces, how many cups of water do you drink a day? _____

How many caffeine beverages do you drink per day? _____ Soda? _____ Alcohol? _____