Physical Therapy Solutions
Solutions for an ACTIVE life

Pelvic Floor Patient Intake Form

Patient name: _____ Date: _____

Describe the current problem that brought you here:

How long has the problem been going on?

Past Medical History

Childbirth History (if applicable):

Date	Type of Delivery (vaginal or Cesarean)	Any complications (ie. Episiotomy/tearing?)	Weight of baby

If more, please list here:

Medical Conditions (check if present):

	Diabetes		History of cancer
	Respiratory condition (ie. Asthma, COPD, chronic cough)		High blood pressure
	Venous problems (ie. Leg swelling, etc.)		Heart disease/heart condition
	GI disorders (ie. IBS, ulcerative colitis, etc.)		Smoker
	Urinary tract disorders (ie. Urinary tract infection, kidney stones, etc.)		Fibromyalgia
	Hormone use (ie. Birth control or estrogen therapy)		Mental health
	Endometriosis, fibroids, or cysts		Neurological conditions

Surgical History:

Please list any surgical procedures you have had to treat this condition and dates:

Medications:

Please list medications you take or provide medication list:

_____

Pain

Please rate your pain on a scale from 0-10 (0 means no pain and 10 means unbearable pain)

0 1 2 3 4 5 6 7 8 9 10

Do you have pain with:

Sexual intercourse	Y	N
Pelvic Exam/Tampon use	Y	N
Back, leg, groin, abdominal pain	Y	N

Test Results

Have you had any urodynamics (bladder) testing? Y N

If yes, please describe results: _____

Bladder / Bowel Habits / Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine or stool
Y/N	Urinary intermittent /slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Recurrent bladder infections
Y/N	Trouble holding back gas/feces	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining