

Provenance Rehabilitation Pelvic Intake Form

Patient Name: _____ Date: _____ DOB: _____

Age: _____ Weight: _____

Gender: Male Female

Occupation: _____ Relationship Status: _____

Hobbies / Leisure Activities:

Exercise Routine:

Briefly describe your current complaint:

When did this problem begin? _____ Is it getting better _____ worse _____ same _____

Rate your feelings as to the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10
0 = not a problem 10 = major problem

Do you now have or do you have a history of the following?

- | | |
|--|--|
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Smoking habit |
| <input type="checkbox"/> Urinary frequency, hesitancy, urgency | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Trouble feeling bladder fullness |
| <input type="checkbox"/> Low back pain/sciatica | <input type="checkbox"/> Pelvic Organ Prolapse |
| <input type="checkbox"/> Multiple Sclerosis | o Type: |
| <input type="checkbox"/> Childhood bladder problems | o Grade: |
| <input type="checkbox"/> Trouble holding back gas | <input type="checkbox"/> Cancer: Type: |
| <input type="checkbox"/> Vaginal dryness | _____ |
| <input type="checkbox"/> Constant dribbling of urine | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Interstitial Cystitis / Painful Bladder | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Constipation, IBS, chronic diarrhea | <input type="checkbox"/> Fatigue, Chronic Fatigue Syndrome |
| <input type="checkbox"/> Chron's Disease | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Joint problems | <input type="checkbox"/> Allergies: |
| <input type="checkbox"/> Abdominal pain | _____ |
| <input type="checkbox"/> Emphysema/bronchitis | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Sexually transmitted diseases | _____ |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fecal incontinence | |

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Ob/Gyn History (if appropriate):

Contraceptive History – Currently using a form of birth control? Y / N

Type of contraception used (condom / pill / IUD / implantable / cervical fluid): _____

If oral contraceptives, how long were they taken? _____

Vaginal deliveries: _____ # C-sections _____ # Episiotomies _____ Forceps Y / N

Complications with delivery / post-partum: _____

Pelvic Surgical History: _____

Menstrual History: Age at onset? _____ Date of last menstrual cycle? _____

Y/N Painful periods? Y/N Pain with ovulation?

Y/N Regular cycles? Y/N Menopause?

Y/N Pain with tampon insertion? Y/N Hormonal Treatment?

Any other significant factors in Ob/Gyn history, please describe:

Sexual Function: For pelvic health, sexual function is an important component to be addressed. These questions are helpful in creating a complete treatment plan for you. However, please know you may choose not to disclose any portion of the following information.

Please circle any applicable items:

Are you currently sexually active? Y / N / It's complicated

Orgasm, erectile, clitoral function – circle any that apply:

Premature ejaculation

Lack of orgasm

Painful penetration (vaginal / rectal)

Pain with orgasm

Difficulty with erection

Arousal without completion

Painful ejaculation

Low libido / lack of desire

Nocturnal erections

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Y/N History of sexual abuse?
Y/N Leakage of urine during intercourse?

Y/N Latex allergy?
Y/N Lubricant allergy / sensitivity

If you use a vaginal or rectal lubricant, what type do you use? _____

Bladder/Bowel Habits:

Number of times you urinate during the day? 3-5 6-9 10-13 >13

Number of times you urinate after going to bed? 0 1-2 2-3 >3

of bowel movements per day? 0-1 1-2 2-3 >3

Consistency of stool: Loose Normal Hard

Y/N Do you take your time to empty your bladder?

Y/N Does your bladder feel full after urination?

Y/N Can you stop the flow of urine?

Y/N Do you have a slow, hesitant urine stream?

Y/N Do you strain to pass urine?

Y/N Do you have triggers that make you feel you can't wait to urinate or defecate?

Y/N Do you strain to pass feces?

Y/N Do you empty your bladder frequently, before the urge?

Y/N Do you ignore the urge to defecate?

Fluid Intake per day (one glass is 8 oz or one cup): 1-2 2-3 3-4 4-5 >5

Number of Caffeinated glasses per day: 0 1-2 2-3 3-4 4-5 >5

Number of Alcoholic glasses per day: 0 1-2 2-3 3-4 4-5 >5

Urine/Fecal Leakage Questions:

Number of urinary leakages daily: 1 2 3 4 5 >5

Number of fecal/bowel leakages daily: 1 2 3 4 5 >5

Severity of Leakage: None Few drops Wets underwear Wets outerwear

Protection worn: None Minipad Maxipad Full undergarment

Position or Activity with Leakage:

Vigorous activity

Strong urge to go

Light activity

Intercourse or sexual activity

Changing positions

No activity changes leakage (constant)

Walking to toilet

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Pelvic Pain Questions:

“I have pain with...”

Sexual intercourse
Urination
Defecation
At Rest
Sitting

Standing
Tight clothes
Exercise
Menstruation
Orgasm

“Pain is located...”

Deep	Penile tip	Rectum
Surface	Clitoris	Tailbone / Coccyx
Vagina	Labia	Tailbone / Sacrum
Urethra	Scrotum	Pubic bone
Anus	Hip	Right side / Left side /
Penile shaft	Pubic	Both sides

Approximate pain onset date: _____

Pain is relieved by: _____

Pain is worsened by: _____

Medications, supplements, herbals or topicals: _____

Due to privacy regulations, we require your permission to email you and to leave messages on your answer machine (re: appointment reminders and/or rescheduling appointments) or with any individual who answers the number you provide, identifying ourselves as “Provenance Rehabilitation.” Do we have your permission to leave such messages and to email you? → Yes → No Initials: _____

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Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred to for evaluation and treatment of pelvic floor dysfunction. I understand that to evaluate and treat my condition it may be necessary, initially and periodically, to have my physical therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length. I understand that no guarantees have been or can be provided regarding the success of therapy. I hereby request and consent to the evaluation and treatment to be provided by the physical therapists of Provenance Rehabilitation.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Signature of parent or guardian (if applicable): _____

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