Provenance
REHABILITATION
specialists in pelvic health & wellness

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Provenance REHABILITATION specialists in pelvic health & wellness

Alpharetta / North Fulton
11975 Morris Road, Suite 310A
Alpharetta, GA 30005
(678) 819-8720, (678) 819-8721 (fax)

Marietta / East Cobb
4343 Shallowford Rd, Ste G3
Marietta, GA 30062

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

Y/N History of sexual abuse? Y/N Latex allergy?

Y/N Leakage of urine during intercourse? Y/N Lubricant allergy / sensitivity

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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 Can you stop the flow of urine?
Y/N Do you strain to pass urine?
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?
Y/N Does your bladder feel full after urination?
Y/N Do you have a slow, hesitant urine stream?
Y/N Do you have triggers that make you feel you can't wait to urinate or 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
- Light activity
- Changing positions
- Walking to toilet
- Strong urge to go
- Intercourse or sexual activity
- No activity changes leakage (constant)

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