Provenance REHABILITATION
specialists in pelvic health & wellness

Alpharetta Office
5530 Windward Pkwy #350
Alpharetta, GA 30004

Cumming Office
540 Lake Center Pkwy #107
Cumming, GA 30040

(678) 819-8720, (678) 819-8721 (fax)

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?

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

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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 Regular cycles?
Y/N Pain with tampon insertion?
Y/N Pain with ovulation?
Y/N Menopause?
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
Painful penetration (vaginal / rectal)
Difficulty with erection
Painful ejaculation
Nocturnal erections
Lack of orgasm
Pain with orgasm
Arousal without completion
Low libido / lack of desire

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

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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 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 voicemail (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 OR 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): _____