Date of initial: _____

Update 1: _____ Update 2: _____ Update 3: _____ Update 4: _____

Pelvic Health Intake Form

Prior to your initial assessment we request that you complete the following intake form as thoroughly as possible. Your responses will be kept private and confidential. During the course of your session, you have the right to stop or alter treatment at any time. Asking questions is always encouraged.

It is also important to note that the sessions do **NOT** include internal assessment or treatment. If this is something you require, a referral will be necessary. Please initial _____

Name: _____ D.O.B: _____

Occupation: _____ Hobbies: _____

Primary complaint(s): _____

_____

When did this start? _____

Is there an event that you associated with the onset of your symptoms/pain? ☐ Yes ☐ No

If yes, please provide details: _____

Has your pain/symptoms spread from its original location? ☐ Yes ☐ No

If yes, please provide details: _____

Are there any life activities that your symptoms/pain interfere with? _____

_____

What health care providers have you seen for these problems and what treatment was provided? _____

_____

_____

On a scale from 1-10, please rate how much this problem/pain bothers you (1= tolerable / 10 = intolerable):

1 2 3 4 5 6 7 8 9 10

Pelvic Pain– please complete the following section if this applies to you

What makes your pain/symptoms worse?

☐ Time of day	☐ Weather	☐ Stress	☐ Full meal	☐ Exercise
☐ Walking	☐ Sitting	☐ Standing	☐ Full bladder	☐ Use of tampon
☐ Intercourse	☐ Urination	☐ Orgasm	☐ Bowel movement	☐ Not relating to any
☐ Coughing/sneezing		☐ Contact with clothing		

Other: _____

What helps soothe your pain/symptoms?

☐ Meditation	☐ Relaxation	☐ Lying down	☐ Laxatives/enema	☐ Massage
☐ Ice	☐ Hot bath	☐ Heating pad	☐ Pain medication	☐ Injection
☐ TENS unit	☐ Music	☐ Bowel movement	☐ Emptying bladder	☐ Nothing

Other: _____

Medical History:

Current medications and what condition it treats: _____

_____

Have you had any abdominal or pelvic surgeries/procedures? (include date): _____

_____

Have you ever had a hernia? ☐ Yes ☐ No Where? _____
Was it repaired with mesh? ☐ Yes ☐ No

Have you ever experienced diastasis recti? (separation of the abdominal wall) ☐ Yes ☐ No

Smoker/Vape? ☐ Yes ☐ No # /day _____ Chronic cough? ☐ Yes ☐ No

Have you ever had any pelvic health conditions? (ie. Yeast infection, Urinary tract infection) ☐ Yes ☐ No

If yes, please provide details: _____

Do you exercise? ☐ Yes ☐ No

If yes, What type of movement do you do?: _____

How often do you train your core? ☐ 1-3x/week ☐ 3-5x/week ☐ never

What types of core exercises do you do? (Ex. crunches, planks):_____

Do you have TMJ issues/jaw pain? ☐ Yes ☐ No

If yes, please provide details: _____

Do you have back or neck problems? ☐ Yes ☐ No Chronic pain? ☐ Yes ☐ No

If yes, please provide details: _____

_____

Digestion & Bowel Function: – please complete the following section if this applies to you

Do you regularly feel the urge to move your bowels?	☐ Yes	☐ No	☐ Sometimes
Do you have constipation?	☐ Yes	☐ No	☐ Sometimes
Do you have loose stools/diarrhea?	☐ Yes	☐ No	☐ Sometimes
Do you have bowel urgency that is difficult to control?	☐ Yes	☐ No	☐ Sometimes
Do you have accidental bowel leakage?	☐ Yes	☐ No	☐ Sometimes
Do you have incomplete emptying?	☐ Yes	☐ No	☐ Sometimes
Do you have pain with a bowel movement?	☐ Yes	☐ No	☐ Sometimes
Do you have pain after a bowel movement?	☐ Yes	☐ No	☐ Sometimes
Does it take longer than 4 minutes to have a bowel movement?	☐ Yes	☐ No	☐ Sometimes
Do you have bloating? (increased pressure in abdomen)	☐ Yes	☐ No	☐ Sometimes

In your opinion, is your fibre intake: ☐ Adequate ☐ Too low ☐ Too high

Do you regularly use: ☐ Laxatives ☐ Stool softeners ☐ Enemas ☐ Natural products

Have you ever been diagnosed with: ☐ IBS ☐ Crohn's Disease ☐ Celiac Disease ☐ Ulcerative Colitis

if yes, when? _____

Do you have any allergies or sensitivities (including foods or latex): _____

_____

Bladder symptoms – please complete the following section if this applies to you

Did you have problems with your bladder during childhood?	☐ Yes	☐ No	☐ Sometimes
Do you have leakage associated with sneezing, coughing, running and/or laughing? Other? _____	☐ Yes	☐ No	☐ Sometimes
Do you have bladder leakage during intercourse?	☐ Yes	☐ No	☐ Sometimes
Do you feel really strong sensations prior to voiding but don't leak?	☐ Yes	☐ No	☐ Sometimes
Does your leakage occur after having a strong urge that feels uncontrollable?	☐ Yes	☐ No	☐ Sometimes
Does your have pain improve when you void/urinate?	☐ Yes	☐ No	☐ Sometimes
Do you have to strain in order to empty your bladder?	☐ Yes	☐ No	☐ Sometimes
Do you have difficulty starting your urine stream?	☐ Yes	☐ No	☐ Sometimes
Do you have dribbling after you get up from the toilet?	☐ Yes	☐ No	☐ Sometimes
Do you have incomplete emptying when you void and feel like you have to go again soon?	☐ Yes	☐ No	☐ Sometimes
Do your bladder problems cause you to leak in bed at night?	☐ Yes	☐ No	☐ Sometimes
Does your incontinence require you to wear bladder control products?	☐ Yes	☐ No	☐ Sometimes

If you answered yes or sometimes, how often? _____ Type: _____

Do you void during the day more than the average person (5-7x)?	☐ Yes	☐ No	☐ Sometimes
If you answered yes or sometimes, how many times? _____			
Do you need to get up at night to void?	☐ Yes	☐ No	☐ Sometimes
If you answered yes or sometimes, how many times? _____			

Fluid intake in 24 hours (# cups) Water _____ Coffee _____ Tea _____ Alcohol _____ Other _____

Gynecological History– please complete the following section if this applies to you

Is your cycle regular? ☐ Yes ☐ No How many days is your cycle? _____

Is your bleeding heavy? ☐ Yes ☐ No Do you experience lots of clotting? ☐ Yes ☐ No

Do you use tampon/Diva Cup? ☐ Yes ☐ No Do you have pain with your period? ☐ Yes ☐ No

Do you use birth control? ☐ Yes ☐ No Type: _____

Do you have feelings of heaviness/pressure in your vagina? ☐ Yes ☐ No

Do you have pain during intercourse? ☐ Yes ☐ No

if yes, please describe: _____

Pregnancies: _____ # Births: _____ # Vaginal deliveries: _____ # C-Sections: _____

Did you have any of the following?

Vacuum-assisted delivery: ☐ Yes ☐ No Episiotomy? ☐ Yes ☐ No

Was there tearing? ☐ Yes ☐ No Grade of tear? _____

Date of last delivery: _____ Length of pushing: _____ Weight of heaviest baby: _____ lbs

Do you/have you suffer(ed) from post-partum depression? ☐ Yes ☐ No

Are you concerned you may have a prolapse? ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes ☐ No If yes, when? _____

Do you have vaginal dryness? ☐ Yes ☐ No

Do you use vaginal moisturizer? ☐ Yes ☐ No If yes, what type? _____

Prostate/Penile Heath – please complete the following section if this applies to you

Does your prostate get painful/irritated? ☐ Yes ☐ No

Has your prostate fluid been expressed and tested? ☐ Yes ☐ No

Have you ever been diagnosed with prostatitis? ☐ Yes ☐ No Date: _____

Have you had a vasectomy? ☐ Yes ☐ No Date: _____

Are you sexually active? ☐ Yes ☐ No

Do you have pain during intercourse? ☐ Yes ☐ No

if yes, please describe: _____

Therapists' notes: