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.

During the course of your treatment / assessment the following areas may / will be of focus: abdomen, diaphragm, rib cage, hips, glutes and thighs (especially upper inner). If you are uncomfortable with any of these, please specify: _____

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 Care Physician: _____

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: _____

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

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? _____

_____

Medical History: Please indicate conditions you are experiencing or have experienced:

Cardiovascular Infections
- ❒ high blood pressure
- ❒ low blood pressure
- ❒ chronic congestive heart failure
- ❒ heart attack
- ❒ phlebitis/varicose veins
- ❒ stroke/CVA
- ❒ pacemaker or similar device
- ❒ heart disease

Infections
- ❒ hepatitis ❒ TB
- ❒ skin conditions ❒ herpes

Soft tissue/joint discomfort
- ❒ jaw ❒ neck
- ❒ shoulders L/R
- ❒ arms L/R ❒ upper back
- ❒ mid back ❒ low back
- ❒ knees L/R ❒ legs L/R

Other: _____

Respiratory
- ❒ chronic cough
- ❒ shortness of breath
- ❒ bronchitis
- ❒ asthma
- ❒ emphysema

Other Conditions
- ❒ loss of sensation, where? _____
- ❒ diabetes, onset: _____
- ❒ epilepsy
- ❒ cancer, where? _____
- ❒ skin conditions, what? _____
- ❒ allergies/sensitivities, to what? _____
- ❒ arthritis

Current medications or treated conditions: _____

_____

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

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):_____

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

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

Did you have any of the following?

Vacuum-assisted delivery/use of forceps: ☐ 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 feelings of heaviness/pressure in your vagina? ☐ Yes ☐ No

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

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

Do you use birth control? ☐ Yes ☐ No If yes, what type: _____

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 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 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
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 _____

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

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? _____

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 ☐ Urination

☐ Use of tampon ☐ Bowel movement ☐ Contact with clothing ☐ Coughing/sneezing

Other (not relating to any): _____

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: _____

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

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

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

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

Therapists' notes:

_____

_____

_____

_____

_____

_____

_____

Date of initial: _____

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