



Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Therapist Name \_\_\_\_\_

# PELVIC HEALTH PHYSICAL THERAPY FORM

## INFORMATION ABOUT YOUR PAIN

What do you think is causing your pain/problem? \_\_\_\_\_

Is there an event associated with the onset of your pain/problem  Yes  No

If yes, describe: \_\_\_\_\_

How long have you had this pain/problem?  Years, how many \_\_\_\_\_  Months, how many \_\_\_\_\_

For each of your symptoms, please check the number that best represents your pain level over the last month.

Scale: 0 = None 10 = Worst Pain Imaginable

| How would you rate your pain                                  | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10                       |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Pain at ovulation (mid-cycle) . . . . .                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain just before period . . . . .                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Level of cramps with period . . . . .                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain after period is over . . . . .                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (not cramps) before period . . . . .                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Deep pain with intercourse . . . . .                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning vaginal pain after sex . . . . .                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pelvic pain lasting hours or days after intercourse . . . . . | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain when bladder is full . . . . .                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain with urination . . . . .                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscle/joint pain . . . . .                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in groin when lifting . . . . .                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Backache . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain with sitting . . . . .                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraine headache . . . . .                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## SURGICAL HISTORY

| Year | Procedures | Surgeon | Findings |
|------|------------|---------|----------|
|      |            |         |          |
|      |            |         |          |
|      |            |         |          |

## SURGICAL HISTORY continued

Please list all other surgical procedures you have had:

| Year | Procedures | Surgeon | Findings |
|------|------------|---------|----------|
|      |            |         |          |
|      |            |         |          |
|      |            |         |          |
|      |            |         |          |

## OBSTETRICAL HISTORY

How many pregnancies have you had? \_\_\_\_\_

Resulting in (#): \_\_\_\_\_ Full 9 months      \_\_\_\_\_ Premature      \_\_\_\_\_ Miscarriage/Abortion  
                                 \_\_\_\_\_ Living Children

Where there any complications during pregnancy, labor, delivery, or post-partum?

\_\_\_\_\_ 4<sup>o</sup> Episiotomy      \_\_\_\_\_ Vaginal Laceration      \_\_\_\_\_ C-Section      \_\_\_\_\_ Forceps  
\_\_\_\_\_ Vacuum      \_\_\_\_\_ Medications for bleeding      \_\_\_\_\_ Post-Partum Hemorrhaging  
\_\_\_\_\_ Other, explain

## GASTROINTESTINAL/EATING

Do you have nausea?       No       With Pain       Taking Medications       With eating  
 Other \_\_\_\_\_

Do you have vomiting?       No       With Pain       Taking Medications       With eating  
 Other \_\_\_\_\_

Have you ever experienced an eating disorder such as anorexia or bulimia?       Yes       No

Are you experiencing rectal bleeding or blood in your stool?       Yes       No

Do you have increased pain with bowel movements?       Yes       No

Do you have pain or discomfort associated with the following:

Change in frequency of bowel movement?       Yes       No

Change in appearance of stool or bowel movement?       Yes       No

Does your pain improve after completing a bowel movement?       Yes       No

## HEALTH HABITS

How often do you exercise       Rarely       1-2 times weekly       3-5 times weekly       Daily

What is your daily caffeine intake (number of cups per day, includes coffee, tea, soda, etc.)?

0       1-3       4-6       >6

How many cigarettes do you smoke per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

**HEALTH HABITS** continued

Do you drink alcohol?  Yes - How much per week? \_\_\_\_\_  No

What is your use of recreational drugs?

Never used  Used in past, not now  Using presently  No answer

How would you describe your diet?

Well balanced  Vegan  Vegetarian  Fried Foods  
Special Foods \_\_\_\_\_ Other \_\_\_\_\_

**URINARY SYMPTOMS**

Do you experience any of the following symptoms:

- Loss of urine with coughing, sneezing, laughing? . . . . .  Yes  No
- Difficulty passing urine? . . . . .  Yes  No
- Frequent bladder infections? . . . . .  Yes  No
- Blood in urine? . . . . .  Yes  No
- Having to void within minutes after voiding? . . . . .  Yes  No
- Loss of urine with urgency or on way to bathroom? . . . . .  Yes  No

**PLEASE CIRCLE THE ANSWER THAT BEST DESCRIBES YOUR BLADDER FUNCTION AND SYMPTOMS:**

|  |       |              |            |          |     |
|--|-------|--------------|------------|----------|-----|
| How many times do you go to the bathroom DURING THE DAY (to void or empty your bladder)?                           | 3-6   | 7-10         | 11-14      | 15-19    | >20 |
| How many times do you go to the bathroom AT NIGHT (to void or empty your bladder)?                                 | 0     | 1            | 2          | 3        | 4   |
| If you get up at night to void or empty your bladder, does it bother you?  | Never | Mildly       | Moderately | Severely |     |
| Are you sexually active?   | Yes   | No           |            |          |     |
| If you are sexually active, do you now or have you ever had pain or symptoms during or after intercourse?          | Never | Occasionally | Usually    | Always   |     |
| Do you have pain with intercourse, does it make you avoid sexual intercourse?                                      | Never | Occasionally | Usually    | Always   |     |
| Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, perineum)? | Never | Occasionally | Usually    | Always   |     |
| Do you have urgency after voiding?   | Never | Occasionally | Usually    | Always   |     |
| If you have pain, is it usually  | Never | Occasionally | Usually    | Always   |     |
| If you have urgency, it is usually   | Never | Occasionally | Usually    | Always   |     |
| Does your pain bother you?   | Never | Occasionally | Usually    | Always   |     |

## SEXUAL AND PHYSICAL ABUSE HISTORY

Have you ever been a victim of emotional abuse? This can include being humiliated or insulted.

Yes

No

No answer

| CHECK THE ANSWER FOR BOTH AN ADULT OR CHILD   | AS A CHILD<br>(13 OR YOUNGER)                            | AS AN ADULT<br>(14 OR OLDER)                             |
|---|--|--|
| Has anyone ever exposed the sex organs of their body to you when you did not want it? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has anyone ever threatened to have sex with you when you did not want to?             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has anyone ever touched the sex organs of your body when you did not want to?         | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has anyone ever made you touch the sex organs of your body when you did not want to?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has anyone ever forced you to have sex when you did not want to?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had any other unwanted sexual experiences that have not been listed above?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please explain: _____   |  |  |
| _____   |  |  |
| _____   |  |  |

| PLEASE CIRCLE THE ANSWER THAT BEST DESCRIBES YOUR EXPERIENCE:                       |       |        |              |          |
|---|-------|--------|--------------|----------|
| When you were a child (13 or younger) did anyone ever hit, kick or beat you?        | Never | Seldom | Occasionally | Severely |
| When you were a child (13 or younger) did anyone ever seriously threaten your life? | Never | Seldom | Occasionally | Severely |
| When you were an adult (14 or older) did anyone ever hit, kick or beat you?         | Never | Seldom | Occasionally | Severely |
| When you were an adult (14 or older) did anyone ever seriously threaten your life?  | Never | Seldom | Occasionally | Severely |