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PELVIC FLOOR INTAKE AND CONSENT

1. What brought you here for treatment?_____
2. What are your goals for treatment?
   _____
   _____
3. Please describe how your symptoms are limiting your personal and/or professional life? And when did your problem start?
   _____
   _____
4. Are you pregnant or trying to become pregnant?_____
5. Are you sexually active? (if yes, what type of contraception?)_____
   _____

Current symptoms: (check or circle all that apply)

Pain:

☐ I do not have pain
☐I have pain with intercourse
☐I have pain with gyn exams/tampon insertion or removal/clothing/manual stimulation
☐I use vaginal lubricants
☐My pain is better/worse during ovulation
☐My pain is better/worse during my menstrual cycle

☐Please rate the **pain** from 0 to 10. At best:____ At worst:____ Average:____
Please describe the quality of the pain._____
Are there any positions that alleviate your pain?_____
Are there any positions that worsen your pain?_____
Do you take any medication for pain?_____

Urinary and Bowel Function: (check or circle all that apply)

☐ I leak urine/gas/stool when I cough / sneeze /yell / laugh / exercise / other

☐ I constantly leak urine/gas/stool

☐ I am sometimes unable to make it to the toilet in time

☐ Things that trigger my urge to urinate/defecate are: running water/ turning key in door / bathroom / cold / coffee / eating

☐ My urine stream is constant / intermittent

☐ I have trouble feeling the urge to urinate/defecate

☐ I have difficulty stopping and starting the flow

☐ I have pain or burning with elimination

☐ I have to strain (*or self cath bladder*) to completely empty my bladder/bowel

☐ I wear protection daily. How many pads/day or week____

☐ I have irritable bowel syndrome/diarrhea/constipation

☐ I have ___ BM per week

☐ I urinate ____ times per day

Fluid intake:

1. I drink ____ servings of water a day
2. I drink ____cups of coffee/tea a day
3. I drink ____servings of alcohol a day

Obstetric history:

1. I had my first period at age _____
2. I am in menopause yes/no
3. Please choose one below:↓

____ I have never been pregnant

____I am pregnant yes/ no (if yes)

a. I am at _____weeks gestation

____I just had my baby

a. I am ____weeks post-partum
b. Type of delivery _____
c. Were there any problems in the pregnancy or delivery?
d. Are there any problems at the surgical site (if any, C section , episiotomy, other)

6. I have had a total of _____pregnancies/_____deliveries/_____miscarraiges

7. Have I experienced any other problems related to pregnancy/delivery including, but not limited to: blood clots/DVTs, preeclampsia, gestational diabetes.

8. Do I have prolapse? yes/no

Medical history:

Does my medical history include:

☐Uterine or ovarian abnormalities including cysts / fibroids / polyps / endometriosis?

☐Cancer, where?

☐Fibromyalgia

☐Pelvic trauma

☐Fractured tailbone

☐Sensitivity to latex

☐Sexually Transmitted disease

☐HIV or AIDS

☐Sexual or physical abuse

☐Hemorrhoids

☐Hepatitis

☐Bladder infections

☐Any Neurological problems

☐Any other medical problems

Surgical history:

Have I had surgery on any of the following:

☐Back/spine

☐Brain

☐Female organs/pelvic

☐Bladder

☐Abdominal