Pelvic History

Chautauqua Physical & Occupational Therapy TCC

Name: _____ DOB: _____ Age: _____

Please answer questions to the best of your ability:

Describe what your problem is: _____

When did this begin? _____

How has your lifestyle/quality of life been altered/changed because of this problem? Such as social activities (not including physical activities), diet/fluid intake, physical activity, and work activity. Please be specific. _____

Date of last physical: _____ Date of last gynecological exam: _____
Have you had any tests/imaging? _____
What are your goals for therapy? _____

Personal medical history- please mark all that apply.

Cancer	Y/N	Emphysema/bronchitis	Y/N	Stroke	Y/N
Heart problems	Y/N	Seizures/Epilepsy	Y/N	Asthma	Y/N
High Blood Pressure	Y/N	Multiple Sclerosis	Y/N	Allergies	Y/N
Ankle Swelling	Y/N	Head injury/TBI	Y/N	Latex Sensitivity	Y/N
Anemia	Y/N	Osteoporosis/osteopenia	Y/N	Hypo/hyperthyroidism	Y/N
Low back pain	Y/N	Chronic Fatigue Syndrome	Y/N	Headaches	Y/N
Tail bone or sacroiliac pain	Y/N	Fibromyalgia	Y/N	Diabetes	Y/N
Drug/Alcohol use	Y/N	Arthritis	Y/N	Kidney Disease	Y/N
Childhood bladder issues	Y/N	Stress Fractures	Y/N	Irritable Bowel Syndrome	Y/N
Depression	Y/N	Rheumatoid Arthritis	Y/N	Hepatitis/HIV/AIDS	Y/N
Anorexia/Bulimia	Y/N	Joint replacement	Y/N	STD/Sexually Transmitted Disease	Y/N
Smoking	Y/N	Bone Fractures	Y/N	Physical/Sexual Abuse	Y/N
Vision/Eye problems	Y/N	Sports Injuries	Y/N	Raynaud's (cold hands/feet)	Y/N
Hearing Loss	Y/N	TMJ/neck pain	Y/N	Pelvic pain	Y/N

Medications/Over the counter- please list name, dose, frequency and route (oral/patch/injection):

_____

_____

_____

Surgical History- please mark all that apply.

Back/Spine	Y/N	Bladder/Prostate	Y/N
Brain/head	Y/N	Bones/Joints/Muscles	Y/N
Female Organs	Y/N	Abdominal/Organs	Y/N

OB/GYN History (Females only)

Vaginal Deliveries #	Y/N	Vaginal Dryness	Y/N
C-sections #	Y/N	Painful Periods	Y/N
Pregnancies #	Y/N	Menopause- when?	Y/N
Difficult Childbirth #	Y/N	Painful vaginal penetration	Y/N
Pelvic Pain	Y/N	Other- please explain	
Episiotomy #	Y/N		

Males only pelvic history

Prostate issues	Y/N	Erectile Dysfunction	Y/N
Shy Bladder	Y/N	Painful Ejaculation	Y/N
Pelvic pain	Y/N	Other-please explain	Y/N

Bladder/Bowel Habits/Problems

Trouble initiating urine stream	Y/N	Slow stream	Y/N
Blood in urine	Y/N	Painful urination	Y/N
Trouble emptying bladder	Y/N	Constipation/straining	Y/N
Difficulty stopping urine stream	Y/N	Current Laxative use	Y/N
Dribbling after urination	Y/N	Trouble emptying bladder completely	Y/N
Straining or pushing to empty bladder	Y/N	Trouble holding back feces/gas	Y/N
Constant urine leakage	Y/N	Recurrent bladder infections	Y/N
Trouble feeling bladder urge	Y/N		Y/N

- Frequency of urination:
  - How many times during the day?
  - During the night?
  - When you have the urge to urinate, how long can you wait before you have to go to the bathroom? (circle one) Minutes? Hours? Not at all? How many minutes or hours?
    - How much urine do you usually pass? (circle one)
      Small Moderate Large

- Frequency of bowel movements per day/week:_____
  - When you an urge to have a bowel movement how long can you wait before you have to go to the bathroom? (circle one) Minutes? Hours? Not at all? How many minutes or hours?_____
  - If constipation is present describe how you manage this. Ex. Medications, suppositories, etc._____
- Average amount of fluid intake per day (8 oz/cup)_____How many of these are caffeinated?_____

- Do you ever feel like an organ is falling out of your vaginal/anal region? Yes or No
  - If yes: please check all that apply, if no skip this question.
    - How many times per month?
    - Is this related to activity or during your period?
    - With standing? Yes or No, For minutes or hours (circle one)
    - With exertion or straining? Yes or No
    - Other (please explain)

  - Do you have bladder leakage? Yes or No (if no skip questions)
    - How many times per day_____ per week_____ per month_____
    - Circle all that apply: My leakage occurs with: coughing, physical exertion, yelling, laughing, sneezing, lifting/bending, water running, key in the door, walking, sex .
    - On average how much urine do you leak? Circle best answer: a few drops, wets underwear, wets outerwear, wets the floor
  - Do you have bowel leakage? Yes or No (if no skip questions)
    - How many times per day____ per week_____ per month_____
    - Circle all that apply: My leakage occurs with: coughing, physical exertion, yelling, laughing, sneezing, lifting/bending, water running, key in the door, walking, sex.
    - How much stool do you lose? Circle best answer: staining in underwear, small amount in underwear, complete emptying of bowel
  - What form of protection do you wear? Circle best answer: none, minimal protection(tissue paper/pantyliner/paper towels), Moderate protection(maxi pad/absorbent product), Maximum protection(diaper/specialty product), Other(please specify)
    - On average how many pads/protection changes are needed in 24 hours?

This consent provides us with your permission to perform reasonable and necessary evaluations and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any satellite offices under common ownership of The Chautauqua Center/Chautauqua Physical & Occupational Therapy including visits that are conducted through telehealth (audio and video) means. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue at any time services being provided.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions. I voluntarily request a physical therapist, physical therapy assistant, occupational therapist, certified occupational therapist assistant or speech-language pathologist as deemed necessary, to perform reasonable and necessary evaluations and treatments for the condition which has brought me to seek care at this practice.

I certify that the insurance information which I have provided is complete and correct. I accept the responsibility of advising and providing TCC/CPT, prior to service, of no fault or workers' compensation information for treatment of eligible inquires or illnesses. I authorize TCC/CPT to release medical information necessary to process insurance claims and release information back to my physician. By my signature below, I hereby consent to treatment, assignment of financial benefits directly to The Chautauqua Center and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consents.

Patient/Parent/Guardian Signature:_____Date:_____

Office Use Only:
Weight:_____Height:_____