Pelvic History

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__________ week____________ 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__________ week____________ 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? ________

I hereby agree & give my consent to medical treatment in treating my physical condition. I give consent to Chautauqua Physical & Occupational Therapy (CPT) to use & disclose my protected health information with my referring physician & for purposes of treatment & payment. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes in my insurance. I authorize release of payment directly to CPT regardless of participation in or out-of-network. Should I default on my financial responsibility & collection action is necessary, I will be responsible for collection costs that are incurred. I give CPT permission to leave a message on my answering phone or with another party. I also give CPT permission to discuss my medical condition with another party. You have the right to review our posted Privacy Policy before you sign this consent. CPT reserves the right to amend the terms of our Privacy Policy at any time. I agree to & understand all the above information.

Emergency Contact: ____________________ Phone: ____________________________

Relation: ____

Patient/Parent/Guardian Signature:____

Date:______________

Email Address: ____

Office Use Only:

Weight:______________________________Height:___________________________________