Columbia Gorge
Physical Therapy & Sports Medicine

Pelvic Floor Intake Form

Name: _____ Date of Birth: _____
HEIGHT: _____ WEIGHT_____
Gender: _____
Gender Pronoun: _____

1. Please describe your primary reason for coming to physical therapy:

   _____

   _____

2. Did this start following a specific event? □ Yes □ No
   a. If yes, please give a brief description of this event:

      _____

3. Do you have pain? □ Yes □ No
   a. If yes, how would you rate your pain?

   0 1 2 3 4 5 6 7 8 9 10

   No pain Worst pain

   b. How would you describe the pain?

   □ Burning □ Numbness □ Sharp □ Itching □ Throbbing □ Electrical
   □ Rawness □ Stabbing □ Other: _____

4. Please check all of the following that aggravate your current symptoms:

□ Sitting
□ Standing
□ Walking
□ Changing positions
□ Light activity (light housework)
□ Vigorous activity (running, jumping)
□ Sexual activities
□ Coughing/sneezing/straining
□ Laughing/yelling
□ Bending/lifting objects
□ Cold weather
□ Triggers - key in the door, running water
□ Nervousness/anxiety
□ Other: _____

5. Since the onset of your symptoms, have you experienced any of the following?

□ Fevers/chills
□ Unexplained weight change
□ Dizziness/fainting
□ Change in bowel/bladder functions
□ Malaise (unexplained tiredness)
□ Unexplained muscle weakness
□ Night pain/sweats
□ Numbness/tingling

6. How would you describe your general health?
   □ Excellent □ Good □ Average □ Fair □ Poor
7. How would you rate your current stress level?
   □ High □ Medium □ Low

8. In the past month, have you often been bothered by feeling down, depressed, or hopeless?
   □ Yes □ No
9. In the past month, have you often been bothered by little interest or pleasure in doing things?
   □ Yes □ No

10. If you answered yes to 9 or 10, is this something with which you would like help with?
□ Yes □ No □ Not today

11. Activity and Exercise: How many times per week do you participate in some sort of exercise?
□ None □ 1-2 days/week □ 3-4 days/week □ 5+ days/week

12. Alcohol Consumption:
□ None □ 3 – 5 drinks per week □ 5+ drinks daily
□ Special occasions only □ 1 – 2 drinks daily
□ 1 – 2 drinks per week □ 3 – 4 drinks daily

13. Smoking History:
Do you currently smoke cigarettes? □ Yes □ No (If in the past, what year did you quit? _____)

Have you ever had any of the following conditions or diagnoses? Please circle all that apply.

Alcohol/Drug Addiction	Epilepsy/Seizures	Osteoporosis
Allergies	Fibromyalgia	Physical or Sexual Abuse
Anemia	Headaches	Sexually transmitted disease
Anorexia/Bulimia	Heart problems	Stress fracture
Asthma	Hepatitis, HIV/AIDS	TMJ/Neck Pain
Arthritis	High Blood Pressure	Depression
Cancer	Hypo/Hyperthyroid	Diabetes
Childhood bladder problems	Irritable Bowel Syndrome	Emphysema/Chronic bronchitis
Interstitial Cystitis	Kidney Disease	Latex Sensitivity
History of Trauma		

Surgical History: Please list all surgical procedures and approximate date:

_____

_____

_____

Are currently taking any medications? (Please list below) **Yes** **No**

Medication Name:	Dosage:	Frequency:	Route of Admin. (Oral, Inhale, Etc.)

OB/GYN History (females only)

Pregnancy #_____
Childbirth: Vaginal Deliveries # _____
Childbirth: C-Section #_____
□Yes □ No: Currently breastfeeding
□ Yes □ No: Pelvic pain
□ Yes □ No: Painful vaginal penetration
□ Yes □ No: Vaginal dryness
□ Yes □ No: Menopause – when? _____

Bladder/Bowel Habits (check all that apply and current concerns

□ Trouble initiating urine stream
□ Slow or intermittent (stop and start) stream
□ Trouble emptying bladder completely
□ Difficulty stopping urine stream
□ Blood in urine
□ Painful urination
□ Trouble feeling bladder urge/fullness
□ Current laxative use

□ Straining or pushing to empty bladder
□ Dribble after urination
□ Constant urine leakage
□ Recurrent bladder infections
□ hip pain
□ heaviness or bulging
□ change bladder bowel

□ Trouble feeling bowel urge/fullness
□ Constipation/straining
□ Trouble holding back gas/feces
□ Other: _____
□ painful scar tissue
□ Low back pain

Skip the following questions if you do not experience any leaking or incontinence:

Number of urine leaking episodes:
____ times per day
____ times per week
____ times per month
____ only with physical exertion (cough, sneeze, etc.)

Number of bowel leaking episodes:
____ times per day
____ times per week
____ times per month
____ only with exertion or strong urge

On average, how much urine do you leak?
____ just a few drops
____ wets underwear
____ wets outerwear
____ wets the floor

How much stool do you leak?
____stool staining
____small amount in underwear
____complete emptying

What form of protection do you wear most often? (Please check only one of the following)
____ None
____ Minimal (tissue paper, pantishield)
____ Moderate (maxipad)
____ Maximum (specialty product/diaper)
____ Other: _____

I acknowledge and understand that I have been referred to PT for evaluation and treatment of pelvic floor (PF) dysfunction. PF dysfunctions include, but are not limited to the following: urinary or fecal incontinence, difficulty with bowel, bladder, or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac, low back, hip or pelvic pain conditions.

I understand that to evaluate my condition it may be useful, initially, and periodically, to have my therapist perform an internal PF muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the PF.

Treatment may include, but not limited to: observation, palpation, use of vaginal weights, dilators, vaginal or rectal sensors for biofeedback and/or muscle stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, you should contact your therapist.

Potential benefits may include an improvement in your symptoms and an increase in your ability

to achieve your goals. You may experience increased strength, awareness, flexibility and endurance in your body. You should gain greater knowledge about your condition and the resources available to you.

3rd Person Available: You have the choice of having a 3rd person in the room with yourself and your PT during the evaluation and treatment sessions. Please let your PT know if you would like a third person present.

I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and technicians of Columbia Gorge Physical Therapy and Sports Medicine.

_____ _____

Patient signature Signature of parent or guardian (if applicable)