Pelvic Rehabilitation Intake

Paso Robles Physical Therapy

General Information

Name _____ Date _____

Symptom Description

1. Describe your primary concern:

2. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date:

4. Since that time, is it: staying the same/getting worse/getting better (circle one)
Why or how?

5. Describe the nature of any pain symptoms (i.e. constant burning, intermittent ache):

6. Describe any previous treatment:

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply:

___ Sitting greater than minutes
___ Walking greater than____minutes
___ Standing greater than __ minutes
___ Changing positions (ie.sit to stand)
___ Light/Vigorous activity (circle one/both)
___ Sexual activity
___ Other, please list

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With nervousness/anxiety
___ No activity affects the problem

8. What relieves your symptoms?

Bowel and Bladder Symptoms

1. Frequency of urination: _____ times per day,_____times per night
2. The usual amount of urine passed is: ___small ___ medium___ large.
3. Average frequency of bowel movements times per day, _____times per week
4. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? minutes, hours, not at all.
5. If constipation is present, describe management techniques:
6. Average fluid intake (one glass= 8 oz/1 cup): ounce/glasses per day.

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Health History
Date of Last Physical Exam: **Tests performed:**

General Health: Excellent Good Average Fair Poor

Mental Health: Current level of stress High Med Low
Current psych therapy? Y/N

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Please describe:

OB/GYN History (female only)	Circle one		Date(s)
Childbirth vaginal deliveries	Yes	No	
Episiotomy	Yes	No	
C-Section	Yes	No	
Prolapse or organ fallout out	Yes	No	
Vaginal dryness	Yes	No	
Painful periods	Yes	No	
Menopause	Yes	No	
Painful vaginal penetration	Yes	No	
Pelvic pain	Yes	No	
Frequency of periods:		Days between cycle:	
Other, please describe:			

Male Pelvic History	Circle one		Date(s)
Prostate disorders	Yes	No	
Shy bladder	Yes	No	
Pelvic pain	Yes	No	
Erectile dysfunction	Yes	No	
Painful ejaculation	Yes	No	
Other, please describe:			

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