MSU Health Care

PELVIC HEALTH PATIENT HISTORY

Legal Patient's Name (First, Middle, Last)	Home Therapy: Are you currently receiving health care services in your home that are billed to your insurance? ☐ Yes ☐ No
Chosen Name:	Pronouns: ☐ he/him/his ☐ she/her/hers ☐ they/them/their

Other Treatment: Have you received any of these treatments this year? ☐ Physical /Occupational / Speech Therapy ☐ Chiropractic/Spinal Manipulation ☐ OMM (Osteopathic Manipulative Medicine)

EMAIL: *(for exercise program)*:

Reason for Visit (Describe Injury):	Goal (What do you want to do better with therapy?):	Date of Onset:

Onset/Timing: ☐ Number of Prior Episodes: ☐ Gradual Onset ☐ Sudden Onset

How did your pain/problem start? ☐ Unknown ☐ While Lifting ☐ Car Accident ☐ A Fall
☐ Trauma ☐ Overuse ☐ Degenerative Process ☐ Recreation/Sport: ☐ Dental Appt
☐ Pregnancy ☐ Other:

BLADDER/URINARY QUESTIONS

How often do you void during the day/waking hours? ☐ < 1 hour ☐ every 1-2 hours ☐ every 2-4 hours ☐ > 4 hours	How often do you wake to void/void at night?

Is your urine stream: ☐ weak ☐ moderate ☐ strong

Do you have trouble initiating urine flow: ☐ Yes ☐ No ☐ Sometimes, details:

Do you every have trouble completely emptying your bladder: ☐ Yes ☐ No ☐ Sometimes, details:

Do you experience pain while voiding? ☐ Yes ☐ No	Pain level: ___/10
Do you every leak urine: ☐ Yes ☐ No If yes, please answer a-e; if no please continue after e:	When did the leaking start?

a) How often do you leak: ☐ a few times per month ☐ a few times per week ☐ 1-2 times per day ☐ multiple times per day

b) When does leaking occur (check all that apply):
☐ cough ☐ sneeze ☐ laugh ☐ getting out of chair ☐ getting out of bed
☐ with exercise ☐ on the way to the bathroom ☐ at night ☐ other:

c) Are you always aware of the leak ☐ Yes ☐ No ☐ sometimes

d) What is the volume of leakage (check all that apply):
☐ couple of drops ☐ couple of tsp ☐ large gush ☐ full bladder empty

e) Do you feel that you have control over leakage?

How much fluid (oz) do you drink per day?

How many of the following do you drink per day:
___ caffeinated beverages ___ carbonated beverages ___ drinks with artificial sugar ___ alcohol

BOWEL/DEFECATION QUESTIONS

How often do you defecate/poop?

What is consistency of stool: ☐ hard pellets ☐ soft and forms ☐ loose and watery

Any pain when defecating? ☐ Yes ☐ No	Lowest pain: ___/10 Highest pain: ___/10
Any strain when defecating? ☐ Yes ☐ No	Rate the level of strain from 0 (no strain) to 10: ___/10

Do you ever feel that you cannot completely empty bowel?

Do you ever leak stool? ☐ Yes, How Often? ___ (If yes, please answer the following) ☐ No

Amount of stool loss: ☐ small stain on undergarments ☐ small amount ☐ large/full bowel loss

Are you aware of leak when it occurs? ☐ Yes ☐ No	Any difficulty wiping/getting clean? ☐ Yes ☐ No
Do you use a stool or Squatty Potty? ☐ Yes ☐ No	

How is your diet? (include # of services of fruits/veggies, sources of fiber)

Any special concerns?

OTHER:

Any current low back pain? ☐ Yes ☐ No Current **__/10** Lowest pain **___/10** Highest pain **___/10**
If yes, please answer the following (would love the same questions that are on the current intake form)

Any current mid/upper back pain? ☐ Yes ☐ No Current **__/10** Lowest pain **___/10** Highest pain **___/10**

Any hip pain? ☐ Right ☐ Left ☐ Both Current **__/10** Lowest pain **___/10** Highest pain **___/10**

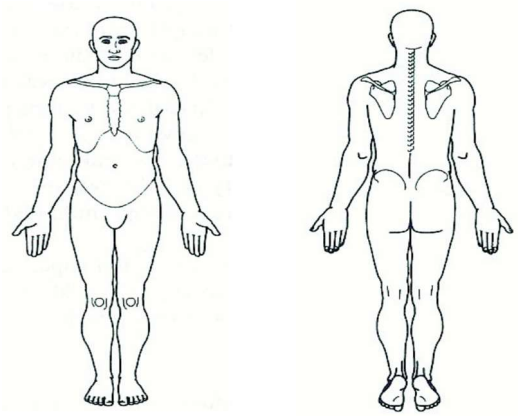
Any tailbone pain? ☐ Yes ☐ No Current **__/10** Lowest pain **___/10** Highest pain **___/10**

Any abdominal pain? ☐ Yes ☐ No Current **__/10** Lowest pain **___/10** Highest pain **___/10**

Any pelvic pain: ☐ Yes ☐ No

☐ SITS bones: Current **__/10** Lowest pain **___/10** Highest pain **___/10**
☐ Vulva: Current **__/10** Lowest pain **___/10** Highest pain **___/10**
☐ Urethra: Current **__/10** Lowest pain **___/10** Highest pain **___/10**
☐ Vagina: Current **__/10** Lowest pain **___/10** Highest pain **___/10**
☐ Anus: Current **__/10** Lowest pain **___/10** Highest pain **___/10**

Please map your areas of discomfort or altered sensation on the body map.
XXX = Pain
000 = Numb/Tingle/Radiating
*** = Weakness



Aggravating Factors *(check all that apply):*

☐ Sitting	☐ Going to/raising from sitting	☐ Walking	☐ Up/Down Stairs	☐ Lying Down
☐ Looking Up Overhead	☐ Reach Overhead	☐ Reach In Front	☐ Reach Behind Back	☐ Reach Across Body
☐ Repetitive Activity	☐ Household Activities	☐ Sports/Recreation	☐ Standing	☐ Squatting
☐ Sustained Bending	☐ Cough	☐ Deep Breathing	☐ Sleeping	☐ Talking
☐ Chewing	☐ Swallowing	☐ Yawning	☐ Stress	
☐ Other:				

Alleviating Factors *(check all that apply):*

☐ Nothing ☐ Medication ☐ Wearing a splint/orthotics
☐ Rest ☐ Cold ☐ Heat ☐ Sitting ☐ Standing
☐ Walking ☐ Lying Down ☐ Stretching ☐ Exercise ☐ Massage
☐ Other:

MEDICAL/SURGICAL HISTORY: a. Please check all that apply

☐ ADD/ADHD	☐ Brain Injury	☐ Fibromyalgia	☐ Lymphedema	☐ Prolapse
☐ AIDS/HIV	☐ Cancer	☐ Fracture	☐ Meniere's Disease	☐ Peripheral Vascular
☐ Allergies/Hayfever	☐ Carpal Tunnel	☐ Head Injury	☐ Muscle/Bone Problem	☐ Rheumatoid Arthritis
☐ Ankle Sprains	☐ Cystic Fibrosis	☐ Headaches	☐ Neck Injury	☐ Serious Illness/Injury
☐ Ankylosing spondylitis	☐ Developmental Delay	☐ Heart Disease	☐ Neurological Disorder	☐ Skin Sensitivities
☐ Anxiety/Depression	☐ Diabetes	☐ Hernia	☐ Neuropathy	☐ Stroke
☐ Arthritis	☐ Endometriosis	☐ Hypermobility / EDS	☐ Obesity	☐ Urinary Problems
☐ Asthma	☐ Epilepsy/Seizures	☐ Hypertension	☐ Orthotics	☐ Vertigo
☐ Back Pain	☐ Falls	☐ Intersitial Cysts	☐ Osteoporosis	
☐ Bleeding Disorder	☐ Fibroids	☐ Lung Disease	☐ PCOS	

☐ Surgery History: *(please list & include dates (mo/year):*

MEDICATIONS: Do you take prescription or nonprescription medication? ☐ YES, ☐ NO If yes, please list below or attach a list.

Prescription	Non-prescription

ALLERGIES: Do you have any allergies? ☐ None ☐ Bees ☐ Latex ☐ Perfumes/lotions ☐ Coconut ☐ pine/linden
☐ Adhesive/tapes ☐ Other *(please specify):*

(We use various emollients and tapes, please feel free discuss ingredients with therapists.)

SOCIAL HISTORY:

Smoking Status: ☐ Never ☐ Former ☐ Current Everyday ☐ Current Some Day ☐ Smoker – Status Unknown

Employment/Work (job/school): ☐ Full time ☐ Part time ☐ Retired ☐ Student ☐ Unemployed ☐ Disability

Occupation:	Sports/Hobbies:

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
(Please include type of exercise, days/wk, and average # minutes)

Marital Status: ☐ Unknown ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner — # of Children:

Living Status: ☐ Alone ☐ Live with others — Pet(s): *(please specify)*

Single/Multi-level home/work: ☐ Single-level home ☐ Multi-level home ☐ Single-level work ☐ Multi-level work

Able to care for self: ☐ Yes ☐ No *(if no, who cares for you?)*

Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone? ☐ **Yes** ☐ **No**

If so, do you feel comfortable giving more details to your therapist today? ☐ **Yes** ☐ **No**

Do you feel safe at home? ☐ **Yes** ☐ **No**

MSU Health Care

PELVIC FLOOR – VAGINAL INTAKE FORM

Patient's Name:	
Chosen Name:	Pronouns: ☐ he/him/his ☐ she/her/hers ☐ they/them/their

VAGINAL QUESTIONS:

Any current pain with tampon use? ☐ Yes ___/10 ☐ No pain ☐ I don't use tampons

Any current pain with Speculum Exam? ☐ No ☐ Yes pain **___/10**
If pain present, how long does it last after exam is complete?

Are you currently sexually active? ☐ Yes ☐ No | How many partners?

Penetrative intercourse? ☐ Yes ☐ No ☐ Sometimes

Pain with penetration could be described as:

☐ Superficial (right at vaginal opening) Lowest pain **___/10** Highest pain **___/10** Duration:

☐ Deep Lowest pain **___/10** Highest pain **___/10** Duration:

My pain is described as (please check all that apply):
☐ tight ☐ burning ☐ tearing/ripping ☐ dull ☐ sharp/stabbing

Do you ever experience a bulge at your vaginal opening? ☐ Yes ☐ No

Do you every have vaginal/perineal heaviness or pressure? ☐ Yes ☐ No

If yes, what makes the bulge/pressure better?

What makes it worse?

Do you orgasm? ☐ Yes ☐ No | Any pain during or after orgasm? ☐ Yes ☐ No

MENSTRUATION HISTORY:

Age of onset:

Do you feel your periods are/were: ☐ fairly regular with low levels of pain ☐ irregular and/or extremely painful

Did you every miss school/work due to period pain? ☐ Yes ☐ No

Are you currently on any birth control? ☐ Yes ☐ No Type:

Age of menopause (if appropriate):

OBSTETRIC HISTORY:

# of pregnancies	# of live births	Type of delivery(s): # of ____ vaginal delivery # of ____ C-section

Any complications with deliveries? (check all that apply)
☐ prolonged pushing ☐ episiotomy ☐ tearing ☐ vacuum/forcep assisted ☐ Other:

Do you feel that you healed well after delivery?