RDLTherapeutic
OUTPATIENT THERAPY | HEALTH | WELLNESS

# Pelvic Health Patient History

Name _____ Age_____ Date_____

1. Describe the current problem that brought you here?_____

_____

2. When did your problem first begin?____months ago or _____ years ago.

3. 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 _____
Why or how?_____

5. If pain is present rate pain on a 0-10 scale 10 being the worst_____ Describe the nature of the pain
(i e. constant, burning intermittent ache)

6. Describe any previous treatment/exercises for this condition _____

_____

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

- ☐ Sitting greater than_____ minutes
- ☐ Walking greater than ____minutes
- ☐ Standing greater than ____minutes
- ☐ Changing positions (i.e. - sit to stand)
- ☐ Light activity (light housework)
- ☐ Vigorous activity/exercise (run/weight lift/jump)
- ☐ Sexual activity
- ☐ Other, please list _____
- ☐ With cough/sneeze/straining
- ☐ With laughing/yelling
- ☐ With lifting/bending
- ☐ With cold weather
- ☐ With triggers -running water/key in door
- ☐ With nervousness/anxiety
- ☐ No activity affects the problem

8. What relieves your symptoms?_____

_____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activ ties (exclude physical activities), specify_____
Diet/Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the w arst

11. What are your treatment goals/concerns?_____

_____

**Since the onset of your current symptoms have you had Check all that opply:**

- ☐ Fever/Chills
- ☐ Unexplained weight change
- ☐ Dizziness or fainting
- ☐ Change in bowel or bladder functions
- ☐ Other /describe_____
- ☐ Malaise (Unexplained tiredness)
- ☐ Unexplained muscle weakness
- ☐ Night pain/sweats
- ☐ Numbness / Tingling

RDL Therapeutic
OUTPATIENT THERAPY | HEALTH | WELLNESS

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

**General Health:** ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor Occupation _____

Hours/week _____ On disability or leave? _____ Activity Restrictions? _____

**Mental Health:** Current level of stress ☐ High ☐ Med ☐ Low Current psych therapy? Yes ☐ No ☐

**Activity/Exercise:** ☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5+ days/week

Describe _____

**Have you ever had any of the following conditions or diagnoses? Check all that apply /describe**

- ☐ Cancer
- ☐ Heart problems
- ☐ High Blood Pressure
- ☐ Ankle swelling
- ☐ Anemia
- ☐ Low back pain
- ☐ Sacroiliac/Tailbone pain
- ☐ Alcoholism/Drug problem
- ☐ Childhood bladder problems
- ☐ Depression
- ☐ Anorexia/bulimia
- ☐ Smoking history
- ☐ Vision/eye problems
- ☐ Hearing loss/problems
- ☐ Stroke
- ☐ Epilepsy/seizures
- ☐ Multiple sclerosis
- ☐ Head Injury
- ☐ Osteoporosis
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Arthritic conditions
- ☐ Stress fracture
- ☐ Rheumatoid Arthritis
- ☐ Joint Replacement
- ☐ Bone Fracture
- ☐ Sports Injuries
- ☐ TMJ/ neck pain
- ☐ Emphysema/chronic bronchitis
- ☐ Asthma
- ☐ Allergies-list below
- ☐ Latex sensitivity
- ☐ Hypothyroid/ Hyperthyroid
- ☐ Headaches
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Irritable Bowel Syndrome
- ☐ Hepatitis HIV/AIDS
- ☐ Sexually transmitted disease
- ☐ Physical or Sexual abuse
- ☐ Raynaud's (cold hands and feet)
- ☐ Pelvic pain

☐ Other/Describe _____

**Surgical /Procedure History**

- ☐ Surgery for your back/spine
- ☐ Surgery for your brain
- ☐ Surgery for your female organs
- ☐ Surgery for your bladder/prostate
- ☐ Surgery for your bones/joints
- ☐ Surgery for your abdominal organs

Other/describe _____

**Ob/Gyn History (females only)**

- ☐ Childbirth vaginal deliveries #___
- ☐ Episiotomy #___
- ☐ C-Section #____
- ☐ Difficult childbirth #___
- ☐ Prolapse or organ falling out
- ☐ Vaginal dryness
- ☐ Painful periods
- ☐ Menopause - when? ____
- ☐ Painful vaginal penetration
- ☐ Pelvic pain

☐ Other /describe _____

**Males only**

- ☐ Prostate disorders
- ☐ Shy bladder
- ☐ Pelvic pain
- ☐ Erectile dysfunction
- ☐ Painful ejaculation

☐ Other /describe _____

| Medications/Vitamins - pills injection patch | Start date | Reason for taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

RDL Therapeutic
OUTPATIENT THERAPY | HEALTH | WELLNESS

Bladder / Bowel Habits / Problems. Check all that apply /describe

- ☐ Trouble initiating urine stream
- ☐ Urinary intermittent /slow stream
- ☐ Trouble emptying bladder
- ☐ Difficulty stopping the urine stream
- ☐ Trouble emptying bladder completely
- ☐ Straining or pushing to empty bladder
- ☐ Dribbling after urination
- ☐ Constant urine leakage
- ☐ Other/describe _____
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Trouble feeling bladder urge/fullness
- ☐ Current laxative use
- ☐ Trouble feeling bowel/urge/fullness
- ☐ Constipation/straining
- ☐ Trouble holding back gas/feces
- ☐ Recurrent bladder infections

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all
3. The usual amount of urine passed is: ☐ small ☐ medium ☐ large.
4. Frequency of bowel movements _____ times per day, _____times per week, or _____.
5. 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.
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz. or one cup) _____ glasses per day.

Of this total how many glasses are caffeinated?_____ glasses per day.

8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

- ☐ None present
- ☐ Times per month (specify if related to activity or your period)
- ☐ With standing for _____ minutes or _____hours.
- ☐ With exertion or straining
- ☐ Other

**Skip questions if no leakage/incontinence**

9a. Bladder leakage - number of episodes

- ☐ No leakage
- ☐ Times per day
- ☐ Times per week
- ☐ Times per month
- ☐ Only with physical exertion/cough

9b. Bowel leakage - number of episodes

- ☐ No leakage
- ☐ Times per day
- ☐ Times per week
- ☐ Times per month
- ☐ Only with exertion/strong urge

10a. On average, how much urine do you leak?

- ☐ No leakage
- ☐ Just a few drops
- ☐ Wets underwear
- ☐ Wets outerwear
- ☐ Wets the floor

10b. How much stool do you lose?

- ☐ No leakage
- ☐ Stool staining
- ☐ Small amount in underwear
- ☐ Complete emptying

11. What form of protection do you wear? (Please complete only one)

- ☐ None
- ☐ Minimal protection (Tissue paper/paper towel/pantishields)
- ☐ Moderate protection (absorbent product, maxipad)
- ☐ Maximum protection (Specialty product/diaper)
- ☐ Other _____

On average, how many pad/protection changes are required in 24 hours? __# of pads

RDL Therapeutic
OUTPATIENT THERAPY | HEALTH | WELLNESS

# PELVIC FOOR INFORMED CONSENT FOR EVALUATION AND TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

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

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor 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 pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

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

**Potential risks:** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

**Potential benefits** may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

**Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

**Cooperation with treatment:**
I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

**No warranty:** I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

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 therapy assistants of RDL Therapeutic Outpatient Therapy.

Date_____ Patient Name: _____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

_____
Witness Signature