



Patient History

Patient Name _____ DOB _____ Date _____

Describe the current problem that brought you here? _____

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

Was your first episode of the problem related to a specific incident? Yes / No

Please describe and specify date _____

Since that time is it: staying the same _____ getting worse _____ getting better _____

Why or how? _____

What are your treatment goals/concerns? _____

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) _____

Describe previous treatment/exercises _____

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

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

What relieves your symptoms? _____

How has your lifestyle/quality of life been altered/changed because of this problem?

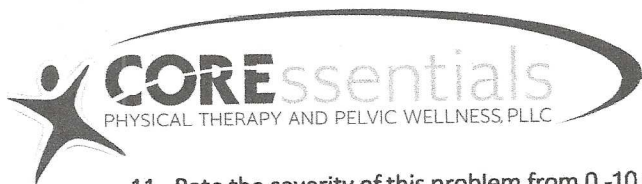
Social activities (exclude physical activities), specify _____

Diet/Fluid intake, specify _____

Physical activity, specify _____

Work, specify _____

Other _____



11. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____

Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling
Y/N	Other /describe _____		

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? Y / N

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? circle all that apply /describe

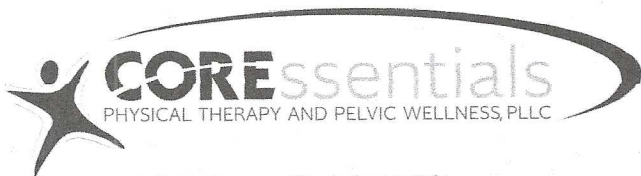
Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone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

Other/Describe _____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe _____



Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries # _____	Y/N	Vaginal dryness
Y/N	Episiotomy # _____	Y/N	Painful periods
Y/N	C-Section # _____	Y/N	Menopause - when? _____
Y/N	Difficult childbirth # _____	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain
Y/N	Other /describe _____		

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic pain		
Y/N	Other /describe _____		

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

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

1. Frequency of urination - awake hours: _____ 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

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

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

9b. Bowel leakage - number of episodes

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

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

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services with COREssentials Physical Therapy and Pelvic Wellness, PLLC.

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____