



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

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

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: _____