restore
PHYSICAL THERAPY

PELVIC FLOOR INTAKE

Name: _____ Date: _____

Preferred Name: _____ Referring Physician: _____

Preferred Pronouns: She/Her He/His They/Them DOB: _____ Height: _____ Weight: _____

Please describe your main problem: _____

_____

_____

When did it begin_____ Is it getting: better / worse / no change

Please describe activities that you are unable to do because of this problem: _____

_____

Medical History

Do you have or have had:	Yes	No
Diabetes		
Osteoarthritis		
Osteoporosis		
Rheumatoid Arthritis		
Headaches		
Cancer		
High Blood Pressure		
Pacemaker		
Heart Disease		
Dizziness/Fainting		
Fevers/Chills		
Weight Changes		
Pelvic Organ Prolapse		
Endometriosis		
Cysts		
Fibroids		
Urinary Tract Infections		

Surgeries:	Date:
Hysterectomy	
C-Section	
Gall Bladder	
Prostatectomy	
Appendectomy	
Hernia repair	
Laparoscopy	
Metoidioplasty	
Phalloplasty	
Vaginoplasty	
Mastectomy	
Gender Affirmation Surgery	
Chest reconstruction	
Other:	

Please list ALL medication/supplements (prescription or over-the-counter) you currently take:

_____

_____

Do you have any allergies? _____

_____

If Applicable:

Have your periods stopped? Yes / No Date of last period: _____

Do you have an IUD? Yes / No Do/did you have pain with your periods? Yes / No

Are you pregnant? Yes / No Are you attempting to get pregnant? Yes / No

How many times have you been pregnant: _____

How many times have you given birth: _____ Vaginal or C-section

Are you on any type of supplemental hormone therapy? Yes / No (If so, please list:_____)

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BLADDER HEALTH INTAKE

If you have no concerns with your bladder, please skip this section	Never	Sometimes	Often	N/A
Do you leak urine when you cough, sneeze, laugh, or when lifting?				
Do you ever have an uncomfortable, strong need to urinate that if you don't reach the toilet you will leak?				
If "yes" to question #2, do you ever leak before you reach the toilet?				
Do you have an urge to urinate when you hear running water?				
Do you have an urge to urinate when your hands are in water?				
Do you ever leak urine during or after sexual intercourse?				
Have you had bladder, urinary or kidney infections?				
Are you troubled by pain or discomfort when you urinate?				
Have you had blood in your urine?				
Do you find it hard to begin to urinate?				
Do you have a slow urine stream?				
Do you strain to pass your urine?				
After you urinate, do you have dribbling or a feeling that your bladder is still full?				
Do you have burning when you urinate?				

Please try to give actual numbers for the following questions:

How many times do you urinate during the day? _____

How many times do you urinate after you go to bed? _____

How often do you leak urine? _____

Do you wear protection? **(Circle one):** None Pantiliner Maxi Pad Diaper/Serenity

How many pads do you use in a day? _____

Leakage equals **(Circle one):** Small (less than 1/2 cup) Large (more than 1/2 cup)

How much warning time do you have to get to the toilet? Seconds or Minutes _____

Fluid Intake: (Includes water and other beverages):

8 oz glasses per day (circle one below): *9+* *6 - 8* *3 - 5* *1 - 2*

Caffeinated drinks per day (circle one): *9 +* *6 - 8* *3 - 5* *1 - 2*

Type of caffeinated beverage(s): _____

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SEXUAL HEALTH INTAKE

Are you currently sexually active? Yes No

Do you experience pain or other problems with sexual activity? Yes No

If yes, please describe: (e.g., pain with initial penetration, painful to touch, pain with thrusting)

_____
_____
_____
_____
_____

Do you have increased pelvic pain with other activities? Yes No
If yes, please describe: (e.g., wearing tight clothes, sitting, pain with gynecology exam)

_____
_____
_____
_____
_____

Does the pelvic pain ever feel like it travels? _____
If yes please describe: _____
_____
_____
_____

BOWEL HEALTH INTAKE

Even if you are not having bowel complaints, please fill out the following section as bowel health can relate to bladder or sexual health complaints

Frequency of bowel movements: (Circle one)

2+ times per day 1 time per day Every other day Once every 4-6 days Weekly

Do you strain to pass your bowels? Yes / No / Sometimes

Do you have pain with bowel movements? Yes / No / Sometimes

Do you have anal fissures? Yes / No

Do you have hemorrhoids? Yes / No

Do you have fecal urgency? Yes / No

Do you have fecal incontinence? Yes / No

Do you still feel full after having a bowel movement? Yes / No

Do you ever have to use your hands to help pass a bowel movement? Yes / No

Do you use enemas? Yes / No If yes, when was the last time you used one _____

Do you take fiber supplements? Yes / No
If yes, please let us know which ones you use: _____

_____
_____

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POSTPARTUM INTAKE (if applicable)

Please fill out proceding section if you are being treated for postpartum care

Date of most recent birth: _____ When was your due date: _____

How many weeks gestation were you at time of delivery: _____

Baby Boy or Girl If multiples, how many?: _____

Please describe main problem(s): _____

_____

Is it getting (circle one): better / worse / same

Please describe activities that you are unable to do because of this problem: _____

_____

Please describe any problems/complications during pregnancy or during delivery: _____

_____

Occupation: _____ When do you return to work (if on leave): _____

How long did you push in your recent deliver _____ (hours or minutes)

C-section of Vaginal birth: _____

Did you have a tear or episiotomy? _____ If so, what degree? _____

How are you feeding your baby? _____ (i.e. breastfeeding, bottle feeding, combination)

Was assistance used in delivery of baby? YES / NO If so: _____ (forceps, vacuum, etc)

Are you experiencing vaginal dryness? YES / NO

Did you have gestation diabetes? YES / NO

Are you currently experiencing hemorrhoids? YES / NO

Are you still bleeding? YES / NO

Have you had a recent infection? YES / NO

Have you been cleared by your provider for intercourse? YES / NO

Are you sexually active? YES / NO

Are you experiencing pain with intercourse? YES / NO