CAMBER PHYSICAL THERAPY
FUSION CHIROPRACTIC

PELVIC HEALTH INTAKE FORM

Name _____ Preferred Name _____

Briefly describe the problem that brought you in today, how it began, and when. _____

_____

_____

Rate the severity of the problem on a scale of 0 – 10. 0 is not a problem. 10 is it significantly affects quality of life. _____

If activities/events cause or aggravate your symptoms, check all that apply OR ☐ no activity affects the problem

- ☐ sitting more than ____ minutes
- ☐ walking more than ____ minutes
- ☐ standing more than ____ minutes
- ☐ changing positions (sit to stand)
- ☐ sexual intercourse
- ☐ light activity (light housework)
- ☐ vigorous activity (run/jump/weight lift)
- ☐ with coughing/sneezing/straining
- ☐ with trigger - running water/key in door
- ☐ other activities _____
- ☐ with nervousness/anxiety
- ☐ with cold weather
- ☐ with lifting/bending
- ☐ with laughing/yelling

If pain is present, please rate on a scale of 0 – 10. 0 is no pain. 10 is worst pain you can imagine. _____

Describe previous treatment or specialists seen for this diagnosis_____

Please check the corresponding box to indicate if you have or have had any of the following conditions.

☐ Fibromyalgia	☐ Multiple sclerosis	☐ Kidney disease
☐ Lupus	☐ Ankle swelling	☐ Alzheimer's disease/dementia
☐ Lyme disease	☐ Seizures/epilepsy	☐ High or low blood pressure
☐ Lymphedema	☐ Traumatic brain/head Injury	☐ Irritable bowel syndrome
☐ Obesity	☐ TIA/CVA/stroke	☐ Anorexia/bulimia
☐ Thyroid disorder	☐ Alcohol/substance abuse	☐ Acid reflux/ulcers
☐ Low back pain	☐ Psychiatric disorder	☐ Raynaud's (cold hand/feet)
☐ Sacroiliac disease	☐ Anxiety/depression	☐ Hernia
☐ TMJ/neck pain	☐ Postpartum depression	☐ Heart disease
☐ Rheumatoid arthritis	☐ Post traumatic stress disorder	☐ Emphysema/chronic bronchitis
☐ Osteoarthritis	☐ Hepatitis	☐ Asthma/breathing disorders
☐ Osteoporosis/osteopenia	☐ HIV/AIDS	☐ Hearing loss/problems
☐ Scoliosis	☐ Sexually transmitted disease	☐ Vision/eye problems
☐ Headaches/migraines	☐ Physical/sexual trauma	☐ Latex sensitivity
☐ Chronic fatigue syndrome	☐ Bowel/bladder dysfunction	☐ Anemia
☐ Joint replacement_____	☐ Painful bladder	☐ Diabetes
☐ Fractures - site _____	☐ Leaking of urine or stool	☐ Cancer – type _____
☐ Currently pregnant # of weeks _____	☐ Childhood bladder problems	☐ Other _____

Indicate surgical history below by checking all that apply.

- ☐ back/spine
- ☐ brain
- ☐ hysterectomy
- ☐ bladder/prostate
- ☐ bones/joints
- ☐ abdominal organs
- ☐ mastectomy
- ☐ hernia repair
- ☐ gallbladder/appendix removed
- ☐ other_____

Female – Indicate history by checking all that apply.

- ☐ # of vaginal deliveries _____
- ☐ # of episiotomies _____
- ☐ date menopause began _____
- ☐ # of c-sections _____
- ☐ difficult childbirth
- ☐ pelvic pain
- ☐ vaginal dryness
- ☐ painful periods
- ☐ other _____
- ☐ painful vaginal penetration
- ☐ prolapse or organ falling out

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Male – Indicate history by checking all that apply.

☐ prostate disorders ☐ painful ejaculation ☐ pelvic pain ☐ shy bladder
☐ erectile dysfunction ☐ other _____

List (or provide list of) all current prescription and over the counter medications/supplements, including start date, dosage, frequency, and reason for taking. Write on back, if needed. _____

_____

_____

List all allergies that you may have. _____

Please check any of the pelvic symptoms you are experiencing.

☐ pelvic pain	☐ trouble feeling bladder urge/fullness	☐ trouble holding back gas/feces
☐ trouble initiating urine stream	☐ dribbling after urination	☐ recurrent bladder infections
☐ urinary intermittent/slow stream	☐ urine leakage	☐ constipation/straining
☐ difficulty stopping urine stream	☐ blood in urine	☐ frequent abdominal bloating/pain
☐ trouble emptying bladder completely	☐ painful urination	☐ other _____
☐ straining/pushing to empty bladder	☐ pain with bowel movements	

How often are you urinating? Every_____ hours Wakes up to void _____ times per night
How long are you able to delay urination? _____ hours
Frequency of bowel movements ____ times per day _____ times per week other _____
When you have an urge to have a bowel movement, how long are you able to delay before you have to use the toilet?
_____ minutes _____ hours or ☐ I can't wait
Do you have the feeling of organ "falling out"/prolapse or pelvic heaviness/pressure? ☐ yes ☐ no
☐ with standing for ____ minutes or ____ hours ☐ with exertion/lifting ☐ other _____
☐ post bowel movements ☐ post exercise
Indicate average water intake (one cup is 8 oz) _____ cups/day Indicate how many caffeinated drinks _____ cups/day

IF NOT EXPERIENCING LEAKAGE OR INCONTINENCE OF BLADDER OR BOWEL, PLEASE SKIP THIS SECTION.

I am experiencing bladder leakage. ☐ yes ☐ no ☐ only with physical exertion/cough
Number of episodes ____ Times/day ____ Times/week _____ Times/month
On average, how much urine do you leak? ☐ a few drops ☐ wets underwear ☐ wets outerwear ☐ wets floor

I am experiencing bowel leakage. ☐ yes ☐ no ☐ only with exertion/strong urge
Number of episodes ____ Times/day ____ Times/week _____ Times/month
On average, how much stool do you lose? ☐ stool staining ☐ small amount in underwear ☐ complete emptying

Indicate what form of protection you wear. ☐ none ☐ minimal (tissue/paper towel/panty shield)
☐ moderate (absorbent product/maxipad) ☐ maximum (specialty product/diaper)
Indicate, on average, how many pad/protection changes are required in 24 hours. _____ # of pads