COMBER 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. ____________________________________

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

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	☐ hysterectomy	☐ bones/joints	☐ mastectomy	☐ gallbladder/appendix removed
☐ brain	☐ bladder/prostate	☐ abdominal organs	☐ hernia repair	☐ 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. ____

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____

List all allergies that you may have. ____

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Please check any of the pelvic symptoms you are experiencing.

☐ pelvic pain	☐ trouble feeling bladder urge/fullness	☐ gas or stool leaking
☐ 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? _______ minutes

Frequency of bowel movements ____ times per day _____ times per week other _________________________

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

Female – Indicate history by checking all that apply.

☐ # of vaginal deliveries _____ ☐ # of c-sections _____ ☐ vaginal dryness ☐ painful vaginal penetration

☐ # of episiotomies _____ ☐ difficult childbirth ☐ painful periods ☐ prolapse or organ falling out

☐ date menopause began ________ ☐ pelvic pain ☐ other ____

Male – Indicate history by checking all that apply.

☐ prostate disorders ☐ painful ejaculation ☐ pelvic pain ☐ shy bladder

☐ erectile dysfunction ☐ other ____

PELVIC HEALTH INTAKE FORM

CONSENT FOR EVALUATION AND TREATMENT (page 1)

The term “informed consent” means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to the patient. 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 and treat my condition, it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination and/or internal treatment. This is done by observing and/or palpating the perineal region including the vagina and/or rectum to 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 to the pelvic region **internally** may be necessary to fully reach desired results and obtain your personal goals of health and wellness. 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.

I understand I have the option to decline an internal pelvic floor examination and internal treatment and acknowledge that declining the internal exam and treatment limits the therapist’s evaluation and ability to treat.

I consent to internal pelvic floor examinations/treatment. ❑ yes ❑ no

I understand I may choose to have another clinical employee in the room during an internal portion of the exam.

I choose to have a chaperone in the room during internal exams/treatment. ❑ yes ❑ no

I understand that I can change the options selected above at any time by completing a new Consent for Evaluation and Treatment.

I understand that if I have experienced past physical or emotional trauma related to the pelvic region, it is best to share this information with my treating therapist.

Patient Signature ______________________________ Date___________________

PELVIC HEALTH INTAKE FORM

CONSENT FOR EVALUATION AND TREATMENT (page 2)

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: I may experience 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.

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.

Plan of Care Agreement: I understand and agree to the following.

1. For optimum care and progress, it is important to keep all scheduled therapy appointments. At those visits, we may advance your exercise and home programs as indicated upon the visit. If it is necessary to cancel an appointment, provide at least 24 hours notice prior to the scheduled appointment time in order to avoid the $50 cancellation fee.

2. Wear comfortable clothing to all visits, or bring a change of clothes for comfort during exercise and treatment.

3. Bring any previous exercise sheets, logs, biofeedback sensors (if issued), and questions I about my current therapy and goals.

My diagnosis, evaluation findings, treatment program, expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program have been explained to me. I have informed my therapist of any condition that would limit my ability to have an evaluation or treatment. My questions about care have been answered to my understanding and satisfaction. I hereby request and consent to evaluation/treatment to be provided by the therapists and PT assistants of Comber Physical Therapy.

Patient name printed ____

Patient/Guardian signature ____ Date ____________________

Therapist signature ____ Date ____________________