Pelvic Health Physiotherapy Intake Form

ATHLETE'S CARE
Sports Medicine Centres

Prior to your initial assessment we request that you complete the following intake form as thoroughly as indicated. Your responses will be kept confidential and forwarded directly to your Pelvic Health Physiotherapist.

Name: _____ Date: _____

Occupation: _____ Hobbies: _____

Primary complaints: _____

_____

When did this start? _____

Is there an event that you associated with the onset of your symptoms/pain? ☐ Yes ☐ No

If so, what? _____

What do you think is causing this issue/pain? _____

What seems to aggravate this issue/pain? _____

Has your pain spread from its original problem? ☐ Yes ☐ No

Are there any life activities that your symptoms/pain interfere with? _____

_____

What health care providers have you seen for these problems and what treatment was provided? _____

_____

On a scale from 1-10, please circle and rate how much this problem bothers you

1 2 3 4 5 6 7 8 9 10

On a scale from 1-10, please circle and rate how motivated you are to correct this problem

1 2 3 4 5 6 7 8 9 10

Medical History

Current medications: _____

Allergies (including latex): _____

Have you had any abdominal or pelvic surgeries/procedures? (Include date) _____

_____

Smoker? ☐ Yes ☐ No # packs/day: _____ Chronic cough? ☐ Yes ☐ No

Yeast infections: ☐ Yes ☐ No How often? _____ Last infection: _____

Treatment: _____

Urinary tract infections: ☐ Yes ☐ No How often? _____ Last infection: _____

Treatment: _____

Do you get blood in your urine? ☐ Yes ☐ No Sometimes

Do you exercise? ☐ Yes ☐ No Type: _____ Frequency: _____

Low back problems: ☐ Yes ☐ No Chronic? ☐ Yes ☐ No

Describe: _____

Mid back problems: ☐ Yes ☐ No Chronic? ☐ Yes ☐ No

Describe: _____

Neck problems: ☐ Yes ☐ No Chronic? ☐ Yes ☐ No

Describe: _____

Have you ever been treated for depression? ☐ Yes ☐ No

Treatment: _____

Have you ever been treated for anxiety? ☐ Yes ☐ No

Treatment: _____

Have you ever been diagnosed with a mental health condition? ☐ Yes ☐ No

If yes, what? _____

Gynecological History - please complete the following section if this applies to you

What age did your period start? _____ Is your cycle regular? ☐ Yes ☐ No

How long is your cycle? _____ Do you suffer from PMS? ☐ Yes ☐ No

Is your bleeding heavy? ☐ Yes ☐ No Do you use tampons? ☐ Yes ☐ No

Do you have pain with your period? ☐ Yes ☐ No

Birth control? ☐ Yes ☐ No Type: _____

Are you sexually active? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No ☐ Sometimes

Do you use lubrication? ☐ Yes ☐ No ☐ Sometimes What type: _____

Are you able to orgasm? ☐ Yes ☐ No ☐ Sometimes

Do you have pain with orgasm? ☐ Yes ☐ No ☐ Sometimes

Do you have pain after orgasm? ☐ Yes ☐ No ☐ Sometimes

How is your libido? ☐ Non-existent ☐ Decreased ☐ Increased ☐ Normal

Pregnancies: _____ # Births: _____ # Vaginal Deliveries: _____ # C-section deliveries: _____

Did you have any of the following: vacuum-assisted delivery? ☐ Yes ☐ No

Episiotomy? ☐ Yes ☐ No Tears? ☐ Yes ☐ No Grade of tear: _____

Date of last delivery: _____ Length of pushing: _____ Weight of heaviest baby: _____

Do you/have you suffered from post-partum depression? ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes ☐ No If so, when? _____

Do you have vaginal dryness? ☐ Yes ☐ No

Do you use vaginal moisturizer? ☐ Yes ☐ No If yes, what type: _____

Have you ever been told you have a prolapse? ☐ Yes ☐ No

Do you physically feel something coming out of your vagina (with your hand)? ☐ Yes ☐ No

Do you have feelings of heaviness/pressure in your vagina? ☐ Yes ☐ No

Were there times during pregnancy, labour or delivery that you or your baby were (or you thought you were) in danger of death or injury? ☐ Yes ☐ No

Have you ever had a bad experience with sex? (Forceful, non-consensual, inappropriate or unwelcome touching?) ☐ Yes ☐ No Please describe to your level of comfort: _____

Prostate/Penile Health - please complete the following section if this applies to you

Does your prostate get painful/irritated? ☐ Yes ☐ No

Has your prostate fluid been expressed and tested? ☐ Yes ☐ No

Have you ever had an abnormal prostate exam? ☐ Yes ☐ No

Date: _____ Last PSA Score: _____

Have you ever been diagnosed with prostatitis? ☐ Yes ☐ No Date: _____

Have you had a vasectomy? ☐ Yes ☐ No Date: _____

Have you ever experienced erectile dysfunction? ☐ Yes ☐ No Date: _____

Are you sexually active? ☐ Yes ☐ No

Do you experience pain during intercourse? ☐ Yes ☐ No

Do you have painful erections? ☐ Yes ☐ No

Do you have premature ejaculation? ☐ Yes ☐ No

Have you ever had a bad experience with sex? (forceful, non-consensual, inappropriate or unwelcome touching?) ☐ Yes ☐ No Please describe to your level of comfort: _____

Sleep Hygiene

Does it usually take you longer than 30 minutes to fall asleep?	☐ Yes	☐ No
Do you wake up more than twice a night?	☐ Yes	☐ No
Do you regularly drink coffee, tea, caffeinated pop or alcoholic drinks?	☐ Yes	☐ No
Do you feel that you are currently under significant stress?	☐ Yes	☐ No
Do you feel stress/anxiety contributes to your sleeping difficulties?	☐ Yes	☐ No
Do you feel that you are sensitive to noises and/or that noises wake you up?	☐ Yes	☐ No
Do you have sources of light in your bedroom at night?	☐ Yes	☐ No
Does your sleeping partner keep you awake?	☐ Yes	☐ No
Do you feel that the air in your bedroom is too hot, cold, or not fresh enough?	☐ Yes	☐ No
Do you feel that your mattress or your pillow is uncomfortable or >10 years old?	☐ Yes	☐ No
Do you sleep on your stomach?	☐ Yes	☐ No
Do you have “creeping, crawling or tingling” feelings in your legs?	☐ Yes	☐ No
Do you think you snore loudly, gasp, or stop breathing during sleep?	☐ Yes	☐ No
Do you take narcotics for pain?	☐ Yes	☐ No

Bladder Symptoms - please complete the following section if this applies to you

Did you have problems with your bladder during childhood? ☐ Yes ☐ No ☐ Sometimes

Do you have leakage associated with sneezing, coughing, running, and/or laughing?

Other? _____ ☐ Yes ☐ No ☐ Sometimes

Do you have leakage during intercourse? ☐ Yes ☐ No ☐ Sometimes

Do you feel really strong sensations prior to voiding but don't leak? ☐ Yes ☐ No ☐ Sometimes

Does your leakage occur after having a strong urge that feels uncontrollable? ☐ Yes ☐ No ☐ Sometimes

Do you have pain when your bladder fills? ☐ Yes ☐ No ☐ Sometimes

Does your pain improve when you void/urinate? ☐ Yes ☐ No ☐ Sometimes

Do you have pain when you void/urinate? ☐ Yes ☐ No ☐ Sometimes

Do you have to strain in order to empty your bladder? ☐ Yes ☐ No ☐ Sometimes

Do you have difficulty starting your urine stream? ☐ Yes ☐ No ☐ Sometimes

Do you have dribbling after you get up from the toilet? ☐ Yes ☐ No ☐ Sometimes

Do you sit on the toilet? ☐ Yes ☐ No ☐ Sometimes

Do you have incomplete emptying when you void and feel like you have to go again soon? ☐ Yes ☐ No ☐ Sometimes

Do your bladder problems cause you to leak in bed at night? ☐ Yes ☐ No ☐ Sometimes

Does your incontinence fluctuate with your cycle? ☐ Yes ☐ No ☐ Sometimes

Does your incontinence require you to wear pads? ☐ Yes ☐ No ☐ Sometimes

If you answered yes or sometimes, how often? _____ Type of pads_____

Do you void during the day more than the average person? ☐ Yes ☐ No ☐ Sometimes

(5-7x/day) If you answered yes or sometimes, how often? _____

Do you need to get up at night to void? ☐ Yes ☐ No ☐ Sometimes

If you answered yes or sometimes, how many times? _____

Fluid Intake in 24 hours

cups of water/day: _____ # cups of coffee/day: _____ # cups of tea/day: _____

cups other fluids/day: _____ # alcoholic drinks/day/week/month: _____

Digestion & Bowel Function

Do you regularly feel the urge to move your bowels? ☐ Yes ☐ No ☐ Sometimes

Do you have constipation? ☐ Yes ☐ No ☐ Sometimes

Do you strain to have a bowel movement? ☐ Yes ☐ No ☐ Sometimes

Do you splint or assist to pass stool? ☐ Yes ☐ No ☐ Sometimes

Do you have loose stools/diarrhea? ☐ Yes ☐ No ☐ Sometimes

Do you use your finger to help evacuate? ☐ Yes ☐ No ☐ Sometimes

Do you have bowel urgency that is difficult to control? ☐ Yes ☐ No ☐ Sometimes

Do you have accidental bowel leakage? ☐ Yes ☐ No ☐ Sometimes

Do you have incomplete emptying? ☐ Yes ☐ No ☐ Sometimes

Do you have pain with a bowel movement? ☐ Yes ☐ No ☐ Sometimes

Do you have pain after a bowel movement? ☐ Yes ☐ No ☐ Sometimes

Does it take longer than 4 minutes to have a bowel movement? ☐ Yes ☐ No ☐ Sometimes

Do you have bloating? (Increased pressure in abdomen) ☐ Yes ☐ No ☐ Sometimes

Do you experience a physical change in abdominal girth when your bowels are full (distension)? ☐ Yes ☐ No ☐ Sometimes

In your opinion, is your fibre intake: ☐ Adequate ☐ Too low ☐ Too high

Do you regularly use: ☐ Laxatives ☐ Stool softeners ☐ Enemas ☐ Natural products

Have you ever been diagnosed with: ☐ Irritable bowel syndrome ☐ Crohn's Disease ☐ Celiac Disease ☐ Ulcerative colitis

If yes, when? _____

Do you have any food allergies or sensitivities?

_____

Pelvic Pain - please complete the following section if this applies to you

What makes your pain worse?

- ☐ Intercourse
- ☐ Orgasm
- ☐ Stress
- ☐ Full meal
- ☐ Bowel movement
- ☐ Full bladder
- ☐ Urination
- ☐ Standing
- ☐ Walking
- ☐ Sexual activity
- ☐ Time of day
- ☐ Sitting
- ☐ Weather
- ☐ Exercise
- ☐ Use of tampon
- ☐ Coughing/sneezing
- ☐ Contact with clothing
- ☐ Not related to anything

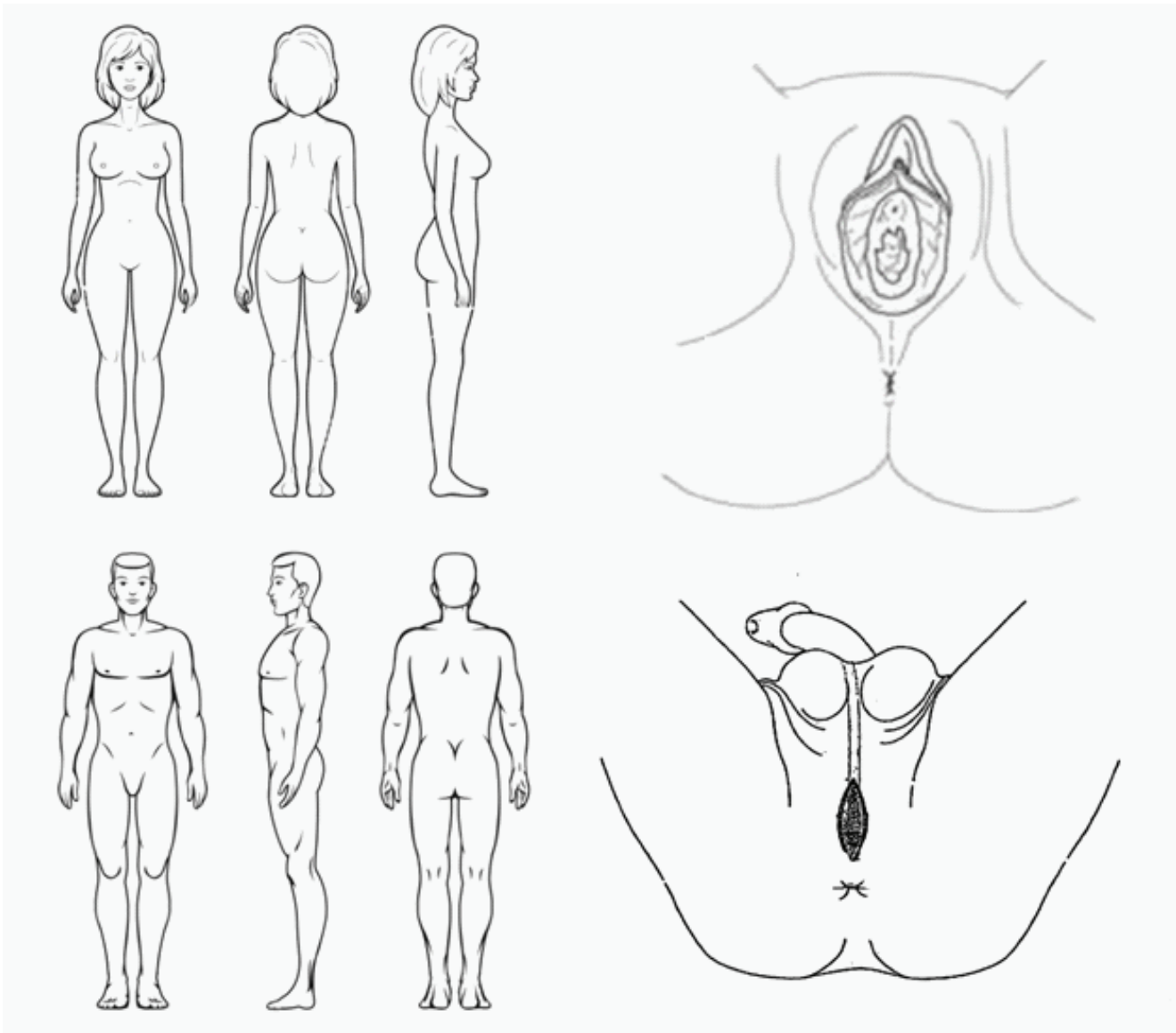
Other: _____

What helps soothe your pain?

- ☐ Meditation
- ☐ Relaxation
- ☐ Lying down
- ☐ Laxatives/enema
- ☐ Massage
- ☐ Ice
- ☐ Hot bath
- ☐ Heating pad
- ☐ Pain medication
- ☐ Injection
- ☐ TENS unit
- ☐ Music
- ☐ Bowel movement
- ☐ Emptying bladder
- ☐ Nothing

Other: _____

Please mark the appropriate pain diagrams- indicate where your symptoms are and describe as able



All patients please complete the following questionnaire:

DASS Questionnaire

Please read each statement and circle a number 0, 1, 2 or 3, which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

0 = Did not apply to me at all
1 = Applied to me to some degree, or some of the time
2 = Applied to me to a considerable degree, or a good part of time
3 = Applied to me very much, or most of the time

I found it hard to wind down	S	0	1	2	3
I was aware of dryness of my mouth	A	0	1	2	3
I couldn't seem to experience any positive feeling at all	D	0	1	2	3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	A	0	1	2	3
I found it difficult to work up the initiative to do things	D	0	1	2	3
I tended to over-react to situations.....	S	0	1	2	3
I experienced trembling (e.g. in the hands)	A	0	1	2	3
I felt that I was using a lot of nervous energy.....	S	0	1	2	3
I was worried about situations in which I might panic and make a fool of myself.....	A	0	1	2	3
I felt that I had nothing to look forward to.....	D	0	1	2	3
I found myself getting agitated.....	S	0	1	2	3
I found it difficult to relax	S	0	1	2	3
I felt down-hearted and blue	D	0	1	2	3
I was intolerant of anything that kept me from getting on with what I was doing.....	S	0	1	2	3
I felt I was close to panic	A	0	1	2	3
I was unable to become enthusiastic about anything.....	D	0	1	2	3
I felt I wasn't worth much as a person.....	D	0	1	2	3
I felt that I was rather touchy.....	S	0	1	2	3
I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	A	0	1	2	3
I felt scared without any good reason	A	0	1	2	3
I felt that life was meaningless.....	D	0	1	2	3

Please complete the following questionnaire if you have pelvic pain:

CSI: PartA

Please check the best response to the right of each statement

I feel un-refreshed when I wake up in the morning.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
My muscles feel stiff and achy.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have anxiety attacks.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I grind or clench my teeth.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have problems with diarrhea and/or constipation.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I need help in performing my daily activities.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I am sensitive to bright lights.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I get tired very easily when I am physically active.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I feel pain all over my body.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have headaches.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I feel discomfort in my bladder and/or burning when I urinate.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I do not sleep well.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have difficulty concentrating.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have skin problems such as dryness, itchiness, rashes.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
Stress makes my physical symptoms get worse.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I feel sad or depressed.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have low energy.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have muscle tension in my neck and shoulders.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have pain in my jaw.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
Certain smells, such as perfumes, make me feel dizzy and nauseated.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have to urinate frequently	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
My legs feel uncomfortable and restless when I am trying to go to sleep at night.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have difficulty remembering things.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I suffered trauma as a child.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
I have pain in my pelvic area.	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always

Total: _____

Please complete the following questionnaire if you have pelvic pain:

PCS Questionnaire

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures, or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are 13 statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you experience pain.

0 = not at all
1 = to a slight degree
2 = to a moderate degree
3 = to a great degree
4 = all the time

When I'm in pain…

(H) _____ I worry all the time about whether the pain will end
(H) _____ I feel I can't go on
(H) _____ It's terrible and I think it's never going to get any better
(H) _____ It's awful and I feel that it overwhelms me
(H) _____ I feel I can't stand it anymore
(M) _____ I become afraid the pain will get worse
(M) _____ I keep thinking of other painful events
(R) _____ I anxiously want the pain to go away
(R) _____ I can't seem to keep it out of my mind
(R) _____ I keep thinking about how much it hurts
(R) _____ I keep thinking about how badly I want the pain to stop
(H) _____ There's nothing I can do to reduce the intensity of my pain
(M) _____ I wonder whether something serious will happen

Total: _____