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Describe the problem(s) for which you seek therapy: _____

_____

When did the current problem(s) begin? _____

Do you have any of the following conditions? (Check all that apply):

☐ Heart Attack / MI	☐ Arthritis	☐ GERD
☐ Heart Disease / Surgery	☐ Broken Bones / Fractures	☐ Stomach Problems / Ulcer
☐ High Cholesterol	☐ Osteoporosis	☐ Multiple Sclerosis
☐ High Blood Pressure	☐ Low Back Pain / Sciatica	☐ Dementia
☐ Asthma	☐ Numbness and Tingling	☐ Parkinson's Disease
☐ COPD	☐ Cancer	☐ Seizures / Epilepsy
☐ Emphysema	☐ Infectious Disease (e.g. Tuberculosis, Hepatitis, HIV)	☐ Skin Diseases
☐ Diabetes		☐ Allergies
☐ Peripheral neuropathy	☐ Kidney Problems	☐ Thyroid Problem
☐ Stroke (CVA)	☐ Liver Disease	☐ Hearing Impairment
☐ TIA	☐ Depression	☐ Visual Impairment
☐ Circulation / Vascular Problems	☐ Mental Illness	☐ Other:_____
☐ Blood Clot / DVT / Pulmonary Embolism	☐ Eating Disorder	

Have you had or do you currently have any of the following conditions (Check all that apply):

☐ Endometriosis	☐ Pelvic Pain	☐ Ulcerative Colitis
☐ Constipation	☐ Vaginal Dryness	☐ Irritable Bowel Syndrome
☐ Abdominal Pain	☐ Sexually Transmitted Disease	☐ Cancer
☐ Fibromyalgia	☐ Frequent Bladder Infections	☐ Frequent yeast infections

<u>Do you have problems associated to your bladder?</u>

☐ Yes
☐ No

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Bladder Health:

How often do you urinate throughout the day? (# of times): _____

How often do you urinate after going to bed? (# of times): _____

How long can you delay the urge to urinate (Minutes / Hours)? _____

Can you stop the flow of urine when on the toilet? Yes / No / Don't Know

Is the volume of urine passed usually: Large / Average / Small / Drops

Do you strain to pass urine or have a slow or hesitant urinary stream? Yes / No

Do you have the feeling that your bladder is still full after urinating? Yes / No

Do you have triggers that make your feel like you cannot wait to get to the toilet? (e.g. running water?) Yes / No

Do you have any bladder leakage? Yes / No

Leakage frequency per day or week:
Leakage amounts: Few drops / Wet Underwear / Wet Outerwear / Other (please specify):
Type of protection and number of changes per day:

If you have bladder leakage, what causes you to leak? (Check all that apply):

☐ Coughing / Sneezing	☐ Laughing	☐ Walking
☐ Running / Jumping	☐ Exercise Class	☐ Feeling Cold
☐ Water Running / Shower	☐ During Intercourse	☐ Before / During Menstruation
☐ Key in the Door / Walking to the Toilet / Strong Urge	☐ When Constipated	☐ Position Changes (e.g. lying to sit, sitting to standing, etc)
☐ No activity changes leakage (constant)	Other:	

Bowel Health:

Frequency of bowel movement: (Number per day or per week):_____

Consistency of stool: Liquid / Loose / Normal / Hard / Small Pellets

Do you use laxatives and / or fiber supplements? Yes / No

If yes, please specify type and frequency of use:_____

Do you experience fecal incontinence? Yes / No

Leakage frequency per day or week:
Leakage amounts: Small spot / Soiled Underwear / Soiled Outerwear / Other (please specify):
Type of protection and number of changes per day:

If you have fecal leakage, what causes you to leak? (Check all that apply):

☐ Coughing / Sneezing	☐ Laughing	☐ Walking
☐ Running / Jumping	☐ Exercise	☐ Strong urge to go
☐ No activity changes leakage (constant)	☐ When Constipated	☐ Position Changes (e.g. lying to sit, sitting to standing, etc)

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☐ Other:

Female Pelvic Floor Symptoms:

Do you have a history of sexual, physical, and / or verbal abuse? Yes / No

If yes, have you had counseling? Yes / No

Do you experience pain or discomfort in any of the following areas? (Check all that apply):

☐ Perineum (space between vagina and rectum)	☐ Vagina	☐ Labia
☐ Clitoris	☐ Below your waist in your rectal area	☐ Below your waist in your pubic area

Which number describes your AVERAGE pain or discomfort when you had symptoms over the past week? (Circle)

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

How often have you had pain or discomfort in the above area(s) over the past week (select one):

☐ Not at all	☐ Often
☐ Rarely	☐ Usually
☐ Sometimes	☐ Always

Sexual History:

Are you currently sexually active?	☐ Yes ☐ No
Have you previously been sexually active?	☐ Yes ☐ No
Do you have or have a history of pain with intercourse?	☐ Yes ☐ No
Do you have or have a history of a sexually transmitted disease?	☐ Yes ☐ No Type:

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Female Pelvic Floor Symptoms (continued):

Obstetrics History:

Are you currently pregnant?	
If so, when are you due?	
Number of Pregnancies over Lifetime:	
Number of Live Births:	

Pregnancy History:

	Child 1	Child 2	Child 3	Child 4	Child 5
Delivery Date					
Weight of Child					
Delivery Type (Vaginal or C-Section)					
Complications during Pregnancy					
Complications during Delivery (Tearing/Episiotomy/Other)					

Menses:

Date of your last menstrual period:_____

Is your menstrual cycle: Regular / Irregular

Do you experience pain related to your menstrual cycle? Yes / No

Location:_____

Are you post menopausal? Yes / No

Age at menopause:

Did you use hormone replacement? Yes / No

General Health:

Do you smoke? Yes / No

If yes, please specify:

Type	Yes or No	Frequency
Cigarettes		
Cigars		
Marijuana		
Other		

Do you consume alcohol? Yes / No

If yes, please specify:

Type	Yes or No	Frequency
Beer		
Wine		
Cocktails / Hard liquor		

Please describe any other controlled substance use: _____

Fluid Intake per day:

	Type	Frequency Per Day
Water		
Caffeine (coffee, tea, cola)		
Other Fluids		

Do you exercise beyond normal daily activities and chores (Check all that apply and describe frequency per week):

Activity	Yes or No	Frequency	Duration of Session
Aerobic classes			
Biking / Spinning			
Gardening / Yard Work			
Golf			
Outdoor Activities (hiking, camping, etc.)			
Running			
Walking			
Team Sports			
Swimming			
Weightlifting			
Yoga / Pilates			
Other			

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Galter Life Center Member? Yes / No