Name:_____ Today's Date: _____

1. What is the main reason(s) you are seeking care today?

- ❑ Urinary dysfunction
- ❑ Bowel dysfunction
- ❑ Sexual function
- ❑ Pain and/or pressure in your abdomen, low back, sacroiliac joint, hips, groin, or elsewhere
- ❑ Other (please specify)
  _____
  _____

2a. When did your main problem begin? _____2b. Was your first of the problem related to a specific incident? Yes/No

3. Since that time is the problem staying the _____ same _____getting worse _____getting better

5. If pain is your primary problem, what is the quality of the pain: △ Sharp △ Burning △ Dull △ Aching

6. Is the pain (*check all that apply)*: △ Continuous △ Activity related △Night pain △ Unpredictable

7. Have you missed work because of this problem? △ Yes △ NO

8. What other treatments/exercises have you tried? *(please list)*

_____ _____

_____ _____

9. Activities/events that cause or aggravate your symptoms: Check/circle all that apply.

__Sitting greater than ___minutes
__Walking greater than ___minutes
__Standing greater than___ minutes
__Changing positions (ie. sit to stand)
__Light activity (light housework)
__Vigorous activity/exercise (run/weight lift/jump)
__Sexual activity
__With cough/sneeze/straining
__With laughing/yelling
__With cold weather
__With triggers (i.e., key in door, running water)
__With nervousness/anxiety
__No activity affects the problem
__Other, please list _____

10. What relieves your symptoms? _____

11. How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify _____
Diet/Fluid intake, specify _____
Physical Activity, specify _____
Work, specify _____
Other _____

12. When did your main problem begin to limit your everyday life? (choose 1)

- ❑ In the past month
- ❑ 1 and 3 months ago
- ❑ 3 and 6 months ago
- ❑ More than 6 months but less than a year ago
- ❑ More than 1 year ago but less than 2 years
- ❑ More than 2 years ago

13. Since the onset of your current symptoms have you had

- ❑ Fever/chills
- ❑ Unexplained weight loss/gain
- ❑ Dizziness or fainting
- ❑ Change in bowel or bladder function
- ❑ Unexplained tiredness
- ❑ Unexplained muscle weakness
- ❑ Night pain/sweats
- ❑ Numbness/tingling

Other/describe _____

10. General Health: Excellent Good Average Poor

Occupation_____Hours/week_____On disability or leave? Activity restrictions? Y/N

11. Activity/Exercise: None 1-2 days/week 3-4/days/week 5+days/week

Describe: _____

12. Mental Health: Current level of stress ___High___Med___Low___Current psych therapy? Y/N

13. Have you ever had any of the following conditions or diagnoses? Check all that apply

- ❑ Cancer
- ❑ Heart problems
- ❑ High blood pressure
- ❑ Ankle swelling
- ❑ Anemia
- ❑ Low back pain
- ❑ Sacroiliac pain/Tailbone pain
- ❑ Alcoholism/drug problem
- ❑ Childhood bladder problems
- ❑ Depression
- ❑ Anorexia/bulimia
- ❑ Smoking history
- ❑ Vision problems
- ❑ Stroke
- ❑ Epilepsy/seizures
- ❑ Multiple Sclerosis
- ❑ Head injury
- ❑ Osteoporosis
- ❑ Chronic fatigue syndrome
- ❑ Fibromyalgia
- ❑ Arthritic conditions
- ❑ Bone fracture
- ❑ Sports injuries
- ❑ TMJ/neck pain
- ❑ Emphysema/chronic bronchitis
- ❑ Asthma
- ❑ Allergies - list below
- ❑ Thyroid problems
- ❑ Headaches/migraines
- ❑ Diabetes
- ❑ Kidney disease
- ❑ Irritable bowel syndrome
- ❑ Hepatitis
- ❑ Sexually transmitted disease
- ❑ Physical or sexual abuse
- ❑ Connective tissue disorder
- ❑ Hernia
- ❑ Autoimmune condition
- ❑ Other/describe_____ _____ _____

14. Surgical/procedure history

Y/N Surgery for your back/spine
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs
Other/describe _____

15. OB/Gyn History (females only)

Y/N Childbirth vaginal deliveries_____
Y/N Episiotomy #_____
Y/N C-section # _____
Y/N Difficult childbirth # _____
Y/N Prolapse or organ falling out
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when? _____
Y/N Painful vaginal penetration
Y/N Pelvic/genital pain _____
Y/N Other/describe _____

16. Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic/genital, pain location_____
Y/N Other/describe _____

Y/N Erectile dysfunction
Y/N Painful ejaculation

17. Medications - pills, injection, patch, vitamins **Start date** **Reason for taking**

_____
_____
_____
_____
_____
_____
_____

18. Bladder/Bowel Habits/ Symptoms

- ❑ Trouble initiating urine stream
- ❑ Urinary intermittent/slow stream
- ❑ Strain or push to empty bladder
- ❑ Difficulty stopping the urine stream
- ❑ Trouble emptying bladder completely
- ❑ Blood in urine
- ❑ Dribbling after urination
- ❑ Constant urine leakage
- ❑ Trouble feeling bladder urge/fullness
- ❑ Recurrent bladder infections
- ❑ Painful urination
- ❑ Blood in stool/feces
- ❑ Other/describe_____

- ❑ Painful bowel movements (BM)
- ❑ Trouble feeling bowel urge/fullness
- ❑ Seepage/loss of BM without awareness
- ❑ Trouble controlling bowel urge
- ❑ Trouble holding back gas/feces
- ❑ Trouble emptying bowel completely
- ❑ Need to support/use hands to complete BM
- ❑ Constipation/straining _____% of the time
- ❑ Current laxative use - type

_____
_____
_____

Typical position for emptying (i.e., sitting, standing, feet propped on stool): _____
Frequency of urination: awake hours ___ times/day, sleep hours ___ times/night
When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
_____
The usual amount of urine passes is ___small ___ medium ___ large
Frequency of bowel movements ___ times/day, ___ times/week, or _____
Bowel movements are typically ___watery ___loose ___ formed/solid ___ pellets ___other_____
When you have an urge to have a BM, how long can you delay before you have to go to the toilet? _____
If constipation is present describe management techniques _____
Average fluid intake (one glass is 8 oz or 1 cup) _____ glasses per day
Of this total, how many glasses are caffeinated? _____ glasses per day
Rate a feeling of organ "falling out"/prolapse or pelvic heaviness/pressure:
___ none present ___times per month (specify if related to activity or your cycle below) ___ with standing for _____ minutes/hours ___ with exertion or straining
Other/describe _____

Bladder leakage - # of episodes

___No leakage
___Times per day
___Times per week
___Times per month
___Only with physical exertion/cough

On average, how much urine do you leak

___No leakage
___Just a few drops
___Wets underwear
___Wets outerwear
___Wets the floor

Bowel leakage - # of episodes

___No leakage
___Times per day
___Times per week
___Times per month
___Only with physical exertion/cough

On average, how much stool do you lose

___No leakage
___Stool staining
___Small amount in underwear
___Complete emptying
___Other_____

What form of protection do you wear? (Please check only one)

___None
___Minimal protection (tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxi pad)
___Maximum protection (specialty product/diaper)
___Other_____

On average, how many pad/protection changes are required in 24 hours? _____# of pads