Northwest Rehabilitation Associates, Inc.

Serving you with specialist care and a personal touch

Pelvic Health Patient Intake Form

Name: _____ Date: _____

Please answer the following questions as honestly and thoroughly as you can. Your responses will help us better understand your condition and provide the best quality of care.

For which symptom(s) are you seeking treatment?

URINARY

- ☐ Incontinence (bladder control, involuntary loss of urine)
- ☐ Urgency (overwhelmingly strong urge to urinate)
- ☐ Frequency (too frequent voiding)

BOWEL

- ☐ Incontinence (bowel control)
- ☐ Problem with Bowel Emptying
- ☐ Problem with Bowel Urgency

OTHER

- ☐ Pelvic Organ Prolapse (bulge or protrusion into the vagina)
- ☐ Pelvic Pain

How long have you had the above problem(s)? _____

What treatments have you tried? _____

Have you had any tests or imaging? Urodynamic / Cystoscope / Ultrasound / MRI / Colonoscopy / Other

Have you had any back, hip, sacral, or pelvic injuries? _____

_____

Have you had any back, hip, pelvic, or abdominal surgeries? _____

_____

Do you currently have any back, hip, or pelvic pain? YES / NO

Phone: (503) 371-2470 **Fax: (503) 339-7736**
3270 Liberty Rd S Salem, OR 97302
www.northwestrehab.com

Northwest Rehabilitation Associates, Inc.

Serving you with specialist care and a personal touch

Bladder Symptoms

How many times per day do you urinate? _____

How many times do you get up to urinate during the night? _____

Do you have difficulty starting urination? YES / NO

Do you strain or push to urinate? YES / NO

Is your urine flow weak or intermittent? YES / NO

Do you leak immediately after voiding (upon standing or as you walk away from the toilet)? YES / NO

Do you feel like you fully empty your bladder? YES / NO

Do you get frequent bladder infections? YES / NO

Are you able to stop your flow of urine intentionally? YES / NO / NEVER TRIED

Urine Leakage

How often do you leak?

Never

- ☐ About once a week or less
- ☐ Two or three times a week
- ☐ About once a day
- ☐ Several times a day
- ☐ All the time

How much urine do you think you leak?

- ☐ None
- ☐ A small amount
- ☐ A moderate amount
- ☐ A large amount

Overall, how much does leaking urine interfere with your everyday life?

0 1 2 3 4 5 6 7 8 9 10

(not at all) (a great deal)

Phone: (503) 371-2470 Fax: (503) 339-7736
3270 Liberty Rd S Salem, OR 97302
www.northwestrehab.com

Northwest Rehabilitation Associates, Inc.

Serving you with specialist care and a personal touch

How many pads do you use per day? _____

Do you associate any of the following activities with urine loss?

- ☐ Coughing
- ☐ Sneezing
- ☐ Laughing
- ☐ Jumping
- ☐ Sit to Stand
- ☐ Bending
- ☐ Exercise
- ☐ Sleeping
- ☐ Lifting
- ☐ Anxiety/Stress
- ☐ Intercourse

Bowel Symptoms

Have you ever seen blood in your stool? YES / NO / HEMMRHOIDS

How many bowel movements do you have? per day _____ per week _____

Which bowel symptom(s) do you experience?

- ☐ Loose Stool
- ☐ Fecal Incontinence
- ☐ Normal Stool
- ☐ Unable to Control Gas
- ☐ Constipation
- ☐ Strain to Pass Stool

Do you get a strong sense of urgency to have a bowel movement? YES / NO

Do you feel your bowels are completely empty after you have a bowel movement? YES / NO

Do you lose stool unintentionally if your stool is loose? YES / NO …is well formed? YES / NO

Do you take any fiber supplements, laxatives, or stool softeners? _____

_____

Sexual Symptoms

Are you sexually active? YES / NO

Do you have any sexually transmitted diseases? YES / NO

If yes, please list: _____

Phone: (503) 371-2470 **Fax: (503) 339-7736**
3270 Liberty Rd S Salem, OR 97302
www.northwestrehab.com

Northwest Rehabilitation Associates, Inc.

Serving you with specialist care and a personal touch

Do you experience any pain, dysfunction, or discomfort with sexual activity? YES / NO

Have you ever been forced to engage in sexual activity against your will? YES / NO

Marital Status: _____

Do you feel safe in your current relationship? YES / NO

Pain

If you have pain related to the condition you are seeking treatment for, please indicate the severity of the pain.

0	1	2	3	4	5	6	7	8	9	10
(no pain)										(the worst pain you can imagine)

Where is the pain? _____

Please describe the quality of the pain (sharp, burning, ache, etc.) _____

_____

Why do you think you have this pain? What do you think caused your symptoms? _____

_____

_____

Obstetric History

How many pregnancies have you had? _____

How many children have you given birth to? _____ Vaginal _____ Cesarean _____

Did any of your deliveries include:

☐ Tearing ☐ Forceps ☐ Episiotomy ☐ Vacuum Delivery ☐ Baby 8.5 lbs+

☐ Prolonged Second Phase Other: _____

Phone: (503) 371-2470 Fax: (503) 339-7736
3270 Liberty Rd S Salem, OR 97302
www.northwestrehab.com

Northwest Rehabilitation Associates, Inc.

Serving you with specialist care and a personal touch

Menstrual History

When was your first period? _____

Are you pregnant? YES / NO

Do you use birth control? What type? _____

Are you going through or have you gone through menopause? YES / NO

Are you using any hormone replacement? What type? _____

General

What is your occupation / what activities fill most of your time? _____

_____

What is your current activity level (sedentary, light, moderate, heavy)? _____

What do you do for exercise? _____

Do you have any allergies to latex, tape, or other topicals? _____

Goals

What are your goals for treatment? _____

_____

What activities, specifically, are difficult or are you unable to perform due to the condition you are seeking treatment for today?

1. _____

2. _____

3. _____

Phone: (503) 371-2470 **Fax: (503) 339-7736**
3270 Liberty Rd S Salem, OR 97302
www.northwestrehab.com