FYZICAL® Therapy & Balance Centers

Pelvic Rehabilitation

ADVANCE Physical Therapy

Name: ____ Date: ____________________

Reason for the Visit: ____

Please Check The Medical Problems That You Have Now or Have Had in the Past:

___ Bladder Problems
___ Bowel Problems
___ Change in bowel/bladder
___ Chronic Fatigue Syndrome
___ Endometriosis

___ Fibroids
___ Incontinence
☐ Fecal ☐Urinary
___ Interstitial Cystitis
___ Kidney Disease

___ Menopause
___ Ovarian Cysts
___ Pain with Intercourse
___ Pelvic/Vulvar pain
___ Prostate Disease
___ Rectal Pain

___ Diet Restriction ____

___ Numbness and Tingling____

___ Allergies____

Please List Your Usual Recreational Activities / Exercise Activities: ________________________

____

Please Check All Previous Surgeries / Date of Surgery:

___ Hysterectomy: _____ abdominal _____ vaginal _____ ovaries removed Date: ______________
___ Hernia Repair Date: ____________
___ Appendectomy Date: ____________
___ Gallbladder Date: ____________
___ Prostate Date: ____________

_____ C-Section Date: ____________
_____ Kidney Surgery Date: ____________
_____ Bladder Repair Date: ____________

___ Other ____

____

Hormone Replacement Therapy? _____ Yes _____ No

If so: Pill ____ Patch ____ Cream ____ Estrogen ____ Progesterone ____

Obstetric History: How many children do you have? ________

If pregnant, due date___________ # Weeks Gestation ___________ # Previous Pregnancies ___________

Vaginal Deliveries ___________ # C- Sections ___________ # Episiotomies _______________

Painful Episiotomy Scar: Y N Other Painful Incisions? ________________________________

Complications during this or prior pegnancies? ________________________________

Level of exercise prior to pregnancy________________________________

Level of exercise now ________________________________

(Please turn over to continue)

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Bladder Habits – Please Check All That Apply:

____ Frequent Urinary Tract Infections
____ Strong Urge to Urinate Produces Involuntary Loss
____ Loss of Urine on the Way to the Bathroom
____ Urgency whey You're Cold or Hear Running Water
____ Loss of Urine with Cough, Sneeze, Lifting, Exercise or Running
____ Loss of Urine Upon Arriving at Bathroom
____ Difficulty Initiating Urine Stream
____ Difficulty Stopping Urination
____ Burning with Urination
____ Pain with Urination
____ Blood in Urine

Bowel Habits – Please Circle or Check

Fecal Leaking – Yes No
Warning / No Warning for Bowel Movement
_____ Difficulty Fully Eliminating BM
_____ Pain with Initiating BM
_____ Pain After BM

Voids/Day _____ # Voids/Night _____ # Episodes Involuntary Urine Loss/Day _____
Amount Lost: _____ Small _____Large ______ Few Drips _____ Continuous Dribbling
Bed Wetting? Y N Do you use protective devices? Y N # Pads/Day ______
Do you restrict fluid intake because of urinary leakage? Y N
Cups caffeinated and/or carbonated beverages/day ________
Cups water/day ______ # Cups juice/day ______
Have you ever taken medication(s) to prevent urine loss? Y N ____

Bowel Habits

Protective devices worn for bowels? Y N If yes, # of pads per day _______
Prolapse? Y N
Do you manually assist BM? Y N
Do you manually reduce your prolapse? Y N
Do you have any gastrointestinal disease? Y N
Are you frequently constipated? Y N
How do you resolve this? ____ High Fiber Diet ____ Laxatives ____ Enemas
Do you frequently have diarrhea? Y N
Do you notice blood in your stool? Y N Often? Y N Hemorrhoids? Y N
Do you have rectal pain? Y N
If yes: ____ At rest ____ Sharp, fleeting pain ____ With bowel movement

Please rate your pain level today on a scale of 1 to 10 (circle the appropriate corresponding number)

Pain Free 0 1 2 3 4 5 6 7 8 9 10 Severe

Please rate how your pain interferes with the quality of your life:

Doesn't Interfere 0 1 2 3 4 5 6 7 8 9 10 Disabling

____ _____________ ________________________________ _________
Patient Signature Date Therapist Signature Date