



Female Incontinence/Pelvic Pain Questionnaire

Patient Name: _____ Date: _____
Age: _____ Height: _____ Weight: _____

Briefly describe your current complaint:

When did this problem begin? _____ Is it getting better _____ worse _____ same _____
Rate your feelings as to the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10
0 = not a problem 10 = major problem

Surgical History:

Have you had surgery for your back/spine, brain, female organs, bladder, prostate, or abdominal organs?
Y/N If yes to these or any other surgeries, please describe:

Ob/Gyn History:

Have you had a history of painful periods, painful penetration, prolapse or a falling out feeling, difficult childbirth? Y/N If yes, please describe:

Childbirth history :

Please describe: # vaginal deliveries: _____ # C-sections _____ # Episiotomies _____
Menopause? Y / N Date of last period: _____

Do you now have or do you have a history of the following? Explain any checked responses and include dates when possible. _____

- | | |
|--|---|
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Low back pain/sciatica | <input type="checkbox"/> Fecal incontinence |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Smoking habit |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Trouble feeling bladder fullness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bladder cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Childhood bladder problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Trouble holding back gas | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Vaginal dryness | |
| <input type="checkbox"/> Constant dribbling of urine | |
| <input type="checkbox"/> Interstitial Cystitis | |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Joint problems | |
| <input type="checkbox"/> Abdominal pain | |
| <input type="checkbox"/> Broken bones | |
| <input type="checkbox"/> Heart disease | |
| <input type="checkbox"/> Emphysema/bronchitis | |
| <input type="checkbox"/> High blood pressure | |



Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred to Sovereign Rehabilitation for evaluation and treatment of pelvic floor dysfunction. I understand that to evaluate and treat my condition it may be necessary, initially and periodically, to have my physical therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length.

I understand that no guarantees have been or can be provided regarding the success of therapy. I hereby request and consent to the evaluation and treatment to be provided by the physical therapists of Sovereign Rehabilitation.

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

Signature of parent or guardian (if applicable): _____