Pelvic Questionnaire

Patient Name:	Date:
Briefly describe your current complaint:	
When did this problem begin?	
How is it changing? (Circle one) Getting: BETTER WORSE NO CHANGE	
Rate your feeling as to the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10 (0= no problem 10 = worst problem imaginable)	
Do you now have or do you have a history of the following?	

☐ Bladder infections	☐ Abdominal pain
☐ Pelvic pain	☐ Sexually transmitted diseases
☐ Painful periods (female)	☐ HIV/AIDS
☐ Low back pain/sciatica	☐ Fecal incontinence
☐ Childhood bladder problems	☐ Smoking habit
☐ Trouble holding back gas	☐ Blood in urine
☐ Constant dribbling of urine	☐ "Falling out" sensation (female)
☐ Interstitial Cystitis	☐ Bladder cancer
☐ Constipation	☐ Painful penetration
☐ Joint problems	☐ Other (please list):
☐ Erectile dysfunction (male)	☐ _____

Female and OB/GYN History	
Please describe: # of vaginal deliveries: _____ # C-Sections: _____ #Episiotomies:_____	
Difficult or complicated childbirth? (Circle One) Yes or No	
If yes, please describe:	
Pelvic surgeries (please describe):	
Menopause? Y / N	Date of last period:

Bowel and Bladder Habits:	
Number of times you urinate during the day?	3-5 6-9 10-13 >13
Number of times you urinate after going to bed?	0-1 1-2 2-3 >3
Number of bowel movements per day? (Circle one)	0-1 1-2 2-3 >3
Number of bowel movements per week? (Circle one)	1-3 3-5 5-9 9-12 >12
Consistency of stool: (Circle one)	Loose Normal Hard
Fluid Intake:	
Intake per day (one glass is 8 oz or one cup):	1 1-2 2-3 3-4 4-5 >5
Number of Caffeinated glasses per day:	0-1 1-2 2-3 3-4 4-5 >5
Number of Alcoholic glasses per day:	0-1 1-2 2-3 3-4 4-5 >5

Bladder / Bowel Questions:			
Does your bladder feel full after urination?	Y / N	Do you empty your bladder frequently, before the urge?	Y / N
Can you stop the flow of urine?	Y / N	Do you ignore the urge to defecate?	Y / N
Do you strain to pass urine?	Y / N	Do you strain to pass feces?	Y / N
Do you have a slow, hesitant urine stream?	Y / N	Do you have "triggers" that make you feel you can't wait to urinate?	Y / N
Urinary / Fecal Leakage Questions:			

Number of urinary leakages daily:			1	2	3	4	5	>5
Number of fecal/bowel leakages daily:			1	2	3	4	5	>5
Severity of Leakage:	(Circle One) None	Few drops	Wets Underwear				Wets Outerwear
Protection worn:	(Circle One) None	Minipad	Maxipad				Full undergarment
"Leakage occurs with…"(Circle those that apply)	Activity Changing positions Walking to toilet		Strong urge to go Intercourse or Sexual activity No activity changes leakage (constant)				

Pelvic Pain Questions:		
Circle appropriate answer(s): "I have pain with..."	Sexual intercourse Urination Defecation Sitting Ejaculation	Standing Tight clothes Menstruation Orgasm Delaying urination / defecation
Circle appropriate answer(s): "Pain is located..."	Deep Surface Vagina Penis - Tip Penis – Shaft Scrotum Urethra Anus	Rectum Entire pelvic region Labia (outer lips) Clitoris Tailbone / Coccyx Tailbone / Sacrum Pubic bone Right side / Left side /Both sides

Informed Consent for Treatment

I acknowledge and understand that I have been referred 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.

Signed:	Dated:

Cancellation & No Show Policy

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. It is your responsibility to make every effort to keep your scheduled appointment and to arrive promptly at the scheduled time. We do realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to the other patients that need to be seen as soon as possible, we hereby request that you notify our office immediately when you realize you will not be keeping your appointment. If you need to cancel or reschedule your appointment, you must do **so at least 24 hours before your scheduled office visit** to avoid paying a fee. This is NOT covered by your medical insurance. Your visits are scheduled so that no other patients may be seen during your appointment time. This form of scheduling allows for privacy and devoted one-on-one therapeutic interventions. Due to the individualized timing of these sessions, a missed appointment without notice means no other patients may be seen at that time either.

The fee for not showing for or cancelling your appointment less than 24 hours prior to the scheduled visit is $50.00.

I hereby acknowledge that I have read and understand the above cancellation and no show policy and that I agree to abide by these guidelines.

Signed:	Dated: