TOTAL MOTION PHYSICAL THERAPY 227 Central Ave. Christiansburg, VA 24073 Phone: 540.585.4841 Fax: 540.585.4842 www.totalmotionpt.com

Pelvic Floor Intake Form

Name _____ Date _____

Age _____ Occupation _____

- Referring Doctor _____
- Other practitioners involved in your care: _____

Special Tests for this condition (Pelvic Ultrasound, Urodynamic testing, Defecography etc.):

_____

Other health services you have received/are receiving for this condition (chiropractor, acupuncture, prior physical therapy, other medical treatments etc.)

_____

Please list all your current prescribed medications, over the counter medications, vitamins, herbs, supplements, and home remedies:

_____
_____

Female Medical History:
Number of Births: # _____
Number of pregnancies: # _____
Birth Control: Y N Type _____
Hormone Replacement Therapy: Y N
Type and dates of use: _____
Date of Menopause Onset: _____
Issues with sexual function: Y N
History of Sexual Trauma: Y N

Other significant medical history:

_____
_____

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Male Medical History

History of Prostate Cancer: Y N
If yes what type of treatment:

_____

Injury to testicles, groin or penis: Y N
If yes describe:

_____

Issues with sexual function: Y N
History of Sexual Trauma: Y N

Other significant medical history:

_____

_____

Please circle any of the following issues you experience:
Urinary Leakage
Fecal Leakage
Feeling of heaviness or dropping in pelvis / vagina
Urinary Frequency
Fecal Frequency
Pain with vaginal insertion (gynecological exam, tampons use, intercourse)
Constipation
Pelvic Pain:
Describe_____

What are your recreational and fitness activities?

_____

What are your goals for therapy?

_____

_____

Pain Assessment:

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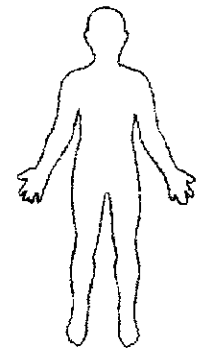
PAST MEDICAL HISTORY

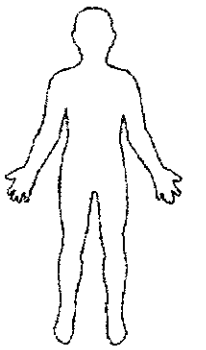
Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Dizzy spells

Other medical conditions (please list):

Do you have pain? Y N
If yes, draw your pain on the body chart below.





Rate your pain intensity on the line below
0 = no pain 10= worst pain possible

0 _____ **10**

Patient Signature _____ Date _____

Therapist Signature _____

227 Central Ave | Christiansburg
757 University City Blvd | Blacksburg
1014 Clement St | Radford
www.totalmotionpt.net

Women's Health Treatment Informed consent:

I understand that I am consenting for physical therapy care by a licensed clinical provider for internal evaluation of pelvic floor muscles. I consent to care for any musculoskeletal dysfunctions I may have, as well as an internal assessment of my musculature. I understand that it is my choice to proceed with and/or terminate care at any time, and will maintain communications with my therapist to this accord.

I would like a 3rd person in the room: Yes___ or No___

_____ _____

Patient's Name (printed) (date)

_____

Patient's Signature