Total Health
OFFERED BY STILLWATER MEDICAL CENTER

Pelvic Health Intake Assessment

405.624.6592

The information you provide is very important to your health and will help our staff determine the care you need as well as any further assessments. Please take time to fully and completely fill out this very important information. **NOTE: If you are currently receiving any type of home health care services, please see the receptionist before completing this form.**

DATE: ____ /____ /_____

GENERAL INFORMATION:

NAME:	
HOME #:	CELL #:
REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:
RETURN TO DOCTOR DATE:	ONSET DATE OF SYMPTOMS:

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

Reason for being referred to therapy:

_____

_____

DEMOGRAPHIC INFORMATION

Cultural/Religious: Any customs, religious beliefs, or wishes that might affect care?

_____

_____

_____

Caregiver Status: Do you have a family member or friend willing and able to assist with:

- ☐ Personal care
- ☐ Dressing
- ☐ Housekeeping
- ☐ Transportation

Home Environment:

- ☐ Stairs, no railing
- ☐ Stairs, railing
- ☐ Ramps
- ☐ Elevator
- ☐ Uneven terrain
- ☐ Other: _____

Living with:

- ☐ Alone
- ☐ Spouse/Significant other only
- ☐ Spouse/Significant others
- ☐ Child (not spouse)
- ☐ Other relative(s) (not spouse or children)
- ☐ Group Setting
- ☐ Personal care attendant

Education:

- ☐ High School
- ☐ College Graduate
- ☐ Graduate School/Advance Degree

How would you rate your health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Major life changes in the past year?

☐ Yes ☐ No

If yes, describe:_____

_____

_____

Smoking:

Do you currently smoke tobacco?

☐ Yes ☐ No

Have you smoked in the past?

☐ Yes ☐ No

Alcohol:

How many days per week do you drink beer, wine, or other alcoholic drink on average?_____

If one beer, one glass of wine, or one cocktail equals one drink, how many do you have on an average day?_____

ACTIVITY

Exercise:

Do you exercise beyond normal daily activities and chores?

☐ Yes ☐ No

Describe the exercise: _____

_____

On average, how many days per week do you exercise or do physical activity? _____

For how many minutes, on an average day? _____

Other:

What activities are you not able to do now that you could do before the problems started? Please be as specific as you can, for instance: "unable to reach over my head."

_____

_____

_____

_____

Current Limitations (check all that apply)

- ☐ Difficulty with self care (bathing, dressing, toileting)
- ☐ Difficulty with home management (household chores)
- ☐ Difficulty sleeping
- ☐ Difficulty with community and work activities/integration
  - ☐ Work/School
  - ☐ Recreational/Play activity
- ☐ Changes with sensation
- ☐ Difficulty with ambulation on
  - ☐ Level Surfaces
  - ☐ Stairs
  - ☐ Ramps
  - ☐ Uneven terrain

MEDICATION:

Please list your medications:

_____

_____

_____

_____

_____

_____

Non-prescription medications: (check all that apply)

- ☐ Advil/Aleve
- ☐ Antacids
- ☐ Ibuprofen/Naproxen
- ☐ Antihistamines
- ☐ Aspirin
- ☐ Decongestants
- ☐ Herbal Supplements (including AZO)
- ☐ Tylenol
- ☐ Miralax
- ☐ Metamucil
- ☐ Others: _____

_____

PAST MEDICAL HEALTH

Cancer	☐ No	☐ Yes – Explain _____
Circulation Problems	☐ No	☐ Yes – Explain: _____
Diabetes	☐ No	☐ Yes – Explain: _____
Falls	☐ No	☐ Yes – Explain: _____
High Blood Pressure	☐ No	☐ Yes – Explain: _____
HIV/AIDS	☐ No	☐ Yes – Explain: _____
Infections	☐ No	☐ Yes – Explain: _____
Kidney Problems	☐ No	☐ Yes – Explain: _____
Low Blood Sugar	☐ No	☐ Yes – Explain: _____
Neurologic Disorders	☐ No	☐ Yes – Explain: _____
Osteoporosis	☐ No	☐ Yes – Explain: _____
Recurrent Urinary Tract Infection	☐ No	☐ Yes – Explain: _____
Respiratory Problems	☐ No	☐ Yes – Explain: _____
Sexually Transmitted Infection	☐ No	☐ Yes – Explain: _____
Surgery	☐ No	☐ Yes – Explain on next page under "Previous Treatment Progression".
Stroke	☐ No	☐ Yes – Explain: _____
Ulcer/Stomach Problems	☐ No	☐ Yes – Explain: _____

Other: _____

PAST MEDICAL HEALTH CONT'D

Latex Allergy: ☐ Yes ☐ No

Medication Allergies: ☐ Yes ☐ No

If yes, please list: _____

_____

_____

_____

Women Only:

Pelvic Inflammatory Disease	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No
Trouble with Menstrual cycle	☐ Yes	☐ No
Complicated pregnancies/deliveries	☐ Yes	☐ No
Pregnant, or might be pregnant	☐ Yes	☐ No
Currently Menstruating	☐ Yes	☐ No

MEDICAL TEST

Medical test within the last few years: (check all that apply)

- ☐ ABI
- ☐ Angiogram
- ☐ Anorectal Manometry
- ☐ Arthroscopy of _____
- ☐ Bladder Scan
- ☐ Biopsy of _____
- ☐ Bone Scan
- ☐ Colonoscopy
- ☐ CT Scan
- ☐ Cystoscopy
- ☐ Defecography
- ☐ Doppler Ultrasound
- ☐ Bronchoscopy
- ☐ Echocardiogram
- ☐ EEG
- ☐ EKG
- ☐ EMG
- ☐ Lymphscintigraphy
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve Conduction Velocity
- ☐ Pap Smear
- ☐ PSA Testing (male only)
- ☐ Pulmonary Function Test
- ☐ Spinal Tap
- ☐ Stool Tests
- ☐ Stress test (Treadmill, bicycle)
- ☐ Urinalysis
- ☐ Urine Test
- ☐ Urodynamic Study
- ☐ X-Rays

CURRENTLY BEING TREATED FOR:

(check all that apply)

- ☐ Any Malignancy
- ☐ Cardiac edema/CHF
- ☐ Infection
- ☐ Renal Failure
- ☐ DVT (Deep vein thrombosis)
- ☐ Hyperthyroidism
- ☐ Cardiac dysrhythmia
- ☐ DVT in pelvic region
- ☐ Recent abdominal surgery
- ☐ Abdominal aortic aneurysm/repair
- ☐ Inflammatory bowel disease
- ☐ Diverticulitis/diverticulosis
- ☐ Presence of clot prevention devices
- ☐ Radiation over abdomen/pelvis
- ☐ Unexplained pain
- ☐ Carotid Sinus hypersensitivity
- ☐ Any Autoimmune condition (lupus, sjorgen's syndrome, rheumatoid arthritis, etc.)

PREVIOUS TREATMENT PROGRESSION

Include therapy, longterm medications, counseling, surgeries, and other interventions

Date Initiated	Date Completed	Types of Treatment

PELVIC/URINARY INFECTIONS

Do you currently have any active infections?

☐ Yes ☐ No

If yes, what kind? _____

_____

If yes, how is the infection being treated? _____

_____

_____

_____

OBSTETRIC HISTORY (IF APPLICABLE):

Number of pregnancies: _____

Number of vaginal deliveries: _____

Number of C-Sections: _____

Birthweigth(s) of children: _____

Position during delivery: _____

With childbirth, did you...?

- ☐ Push for 2 hours or more
- ☐ Have forceps or a vacuum delivery
- ☐ Have a episiotomy (surgical cut)
- ☐ Have a tear
- ☐ Injure your tailbone

GYNECOLOGIC HISTORY: (Women Only)

Do you or have you ever experienced:
(mark all that apply)

- ☐ Pain with sexual intercourse, pelvic exam, or tampon insertion
- ☐ Painful menstrual period
- ☐ Irregular periods
- ☐ Feeling of "falling out"
  - ☐ All day
  - ☐ In the evenings
- ☐ Menopause

BLADDER SYMPTOMS:

How many times per day do you void? _____

How many times do you get up at night to void? _____

Do you ever experience leakage of urine (even a few drops)? ☐ Yes ☐ No

If yes:

1.) How much?
- ☐ few drops
- ☐ wet underwear/pad
- ☐ wet outerwear

2.) When does it happen? (Check all that apply.)
- ☐ with exercise
- ☐ lifting, bending, twisting
- ☐ on the way to the bathroom
- ☐ with intercourse
- ☐ coughing, laughing, sneezing
- ☐ with feeling of urgency

Do you use a:
- ☐ pad
- ☐ pantyliner

If yes, how many per day? _____

How many per night? _____

BOWEL SYMPTOMS:

Do you strain or push to have a bowel movement?
☐ Yes ☐ No

How much water do you drink in a day? _____

Do you drink caffeinated drinks? ☐ Yes ☐ No

Do you use laxatives? _____

If yes, what kind and how much? _____

What does your typical bowel movement look like?

- ☐ 1 - Separate hard lumps, like nuts (hard to pass
- ☐ 2 - Sausage-shaped but lumpy
- ☐ 3 - Like a sausage but with cracks on its surface
- ☐ 4 - Like a sausage or snake, smooth and soft
- ☐ 5 - Soft blobs with clear-cut edges (passed easily)
- ☐ 6 - Fluffy pieces with ragged edges, a mushy stool
- ☐ 7 - Watery, no solid pieces. Entirely liquid.

QUALITY OF LIFE

Have you restricted any of your activities because of incontinence (urine or bowel leakage) or pain? (i.e. walking, dancing, traveling) ☐ Yes ☐ No

If yes, list specific examples: _____

Have you had changes in intimate relationships/sexual funtion due to incontinence or pain? ☐ Yes ☐ No

If yes, list specific examples: _____

Is there anything else you would like share concerning the topics on this page?

PAIN ASSESSMENT

Do you have pain? ☐ Yes ☐ No

If yes, where is it located? _____

_____

Please mark areas of pain on the diagrams below.

What makes the pain better: _____

_____

_____

What makes the pain worse: _____

_____

_____

Pain Intensity:

0 1 2 3 4 5 6 7 8 9 10

< NO PAIN WORST POSSIBLE PAIN >

Duration of Pain: ☐ Constant ☐ Intermittent ☐ NA

Describe the pain: _____

_____

Numbness/Tingling/Altered Sensation? ☐ Yes ☐ No

If yes, describe: _____

_____

_____

PAIN INDICATOR

KEY

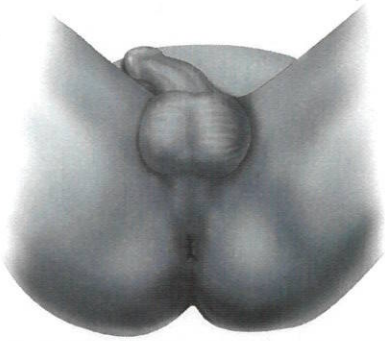
X = Sharp Sensation **+ = Burning Sensation**

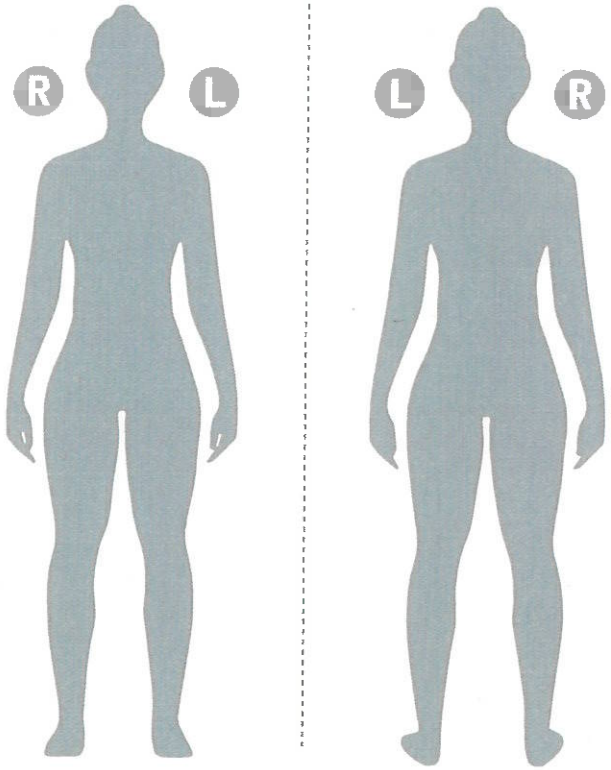
0 = Numbness or Tingling **> = Radiating Pain**

 # = Dull Aching

FEMALE

MALE





GOALS

Patient/Family Concerns and Goals:

Please describe your goals for treatment. List them in order of importance to you.

1. _____
2. _____
3. _____
4. _____

The information I provided is true and correct to the best of my belief.

Patient Name: _____

Patient (or Legal Guardian) signature:

_____

Date: _____

Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, **how much they bother you**. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptom scale:

0 = not present
1= not at all
2 = somewhat
3 = moderately
4 = quite a bit

Pelvic Organ prolapse Distress Inventory 6 (POPDI-6)

Do You...	NO	YES
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal distress Inventory 8 (CRAD-8)

Do You...	NO	YES
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary distress Inventory 6 (UDI-6)

Do You...	NO	YES
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I have the option of having a second person present in the room during the procedure and _____ choose _____ refuse this option.

Date: _____ Patient Name: _____

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

_____

Witness Signature