

Health Information

Self-rate general health:

- excellent fair poor

Describe your activity level / exercise routine:

What is your stress level?

- Low Medium High

Are you seeing any other health professionals for this condition? _____

Surgical / Procedure History

- surgery for back/spine surgery for abdominal organs
 surgery for brain surgery for bones/joints
 surgery for male organs surgery for bladder/rectum

Urology/Colorectal History

- Benign Prostatic Hypertrophy hemorrhoids
 Elevated PSA or prostate surgery hernia
 Injury to groin, testes, or penis low testosterone
 Transurethral Resection of Prostate (TURP) Androgen Deprivation Therapy (ADT)

General Medical History

Have you ever had any of the following? (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> enlarged prostate | <input type="checkbox"/> frequent urination | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> sexually transmitted diseases | <input type="checkbox"/> irritable bowel syndrome | <input type="checkbox"/> urinary tract infections |
| <input type="checkbox"/> hip or tailbone pain | <input type="checkbox"/> stroke | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> cancer | <input type="checkbox"/> headaches |
| <input type="checkbox"/> pelvic pain | <input type="checkbox"/> acid reflux/belching | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> childhood bladder problems | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> asthma |
| <input type="checkbox"/> smoking history | <input type="checkbox"/> chronic fatigue syndrome | <input type="checkbox"/> allergies |
| <input type="checkbox"/> alcohol/drug problems | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> latex sensitivity |
| <input type="checkbox"/> depression | <input type="checkbox"/> diverticulosis/diverticulitis | <input type="checkbox"/> hypo / hyperthyroid |

Have you ever been taught or told to do pelvic floor exercises or Kegels before? YES NO

Occupational Information

Occupation: _____

- full time retired unemployed
 homemaker retired student

On average, how much time per day do you spend:

- | | | | | |
|----------|----------------------------------|----------------------------------|---------------------------------|--------------------------------|
| Sitting | <input type="checkbox"/> 0-3 hrs | <input type="checkbox"/> 3-6 hrs | <input type="checkbox"/> 6-8hrs | <input type="checkbox"/> >8hrs |
| Standing | <input type="checkbox"/> 0-3 hrs | <input type="checkbox"/> 3-6 hrs | <input type="checkbox"/> 6-8hrs | <input type="checkbox"/> >8hrs |
| Computer | <input type="checkbox"/> 0-3 hrs | <input type="checkbox"/> 3-6 hrs | <input type="checkbox"/> 6-8hrs | <input type="checkbox"/> >8hrs |
| Sleeping | <input type="checkbox"/> 0-3 hrs | <input type="checkbox"/> 3-6 hrs | <input type="checkbox"/> 6-8hrs | <input type="checkbox"/> >8hrs |
| Driving | <input type="checkbox"/> 0-3 hrs | <input type="checkbox"/> 3-6 hrs | <input type="checkbox"/> 6-8hrs | <input type="checkbox"/> >8hrs |

Men's Pelvic Dysfunction Intake Form

NAME: _____ DATE: _____

Present Condition History

1. Describe your main problem or reason for your visit:

On the diagram below, please indicate where your current pain or problem is located:



2. When did it begin? (please indicate a specific date if possible) _____

3. Since onset, are your symptoms getting: (check one)
 staying the same getting worse getting better

4. Rate the degree of bother or severity of this problem from 0-10 (0 being no problem and 10 being the worst): _____

5. 1 in 4 adults have been in an abusive situation (physically or emotionally threatened, insulted, beaten, injured or made to take part in sexual activities against your will). Have you ever been or are you now in an abusive situation? YES NO

Pain and Sexual Function

6. Pain: Do you experience an increase in your pain with any of the following: (check all that apply)

- Sexual intercourse: *During, starting or after sexual intercourse?* _____
- Do you experience pain with ejaculation or orgasm? _____
- Certain Postures (sitting, standing, etc), or positions? _____

With a specific activity or exercise? _____

At a certain time of day? _____

Other: _____

7. If you have pain, describe it: (*stinging, burning, ripping, friction, throbbing*) _____

8. What do you do to alleviate your pains?

9. Please use a scale of 0 (no pain) to 10 (worst pain):

Current pain: _____ Worst Pain: _____ Least Pain: _____

10. Are you sexually active? YES NO

11. Do you have sexual desire? YES NO

If yes, can you get aroused? YES NO

Can you reach orgasm? YES NO

Bladder Activity

12. Frequency of urination: ____ times during the day and ____ times at night.

13. Do you experience any leakage of urine or feeling of urgency during any of the following:

- Coughing, laughing, or sneezing
- With the strong urge to go to the bathroom
- With running water
- Exercising or running
- Other: _____
- On the way to the bathroom
- Immediately after using the bathroom
- With sexual intercourse
- As a child (including bed wetting)

14. How often do you leak urine?

- no leakage
- ____ times per day
- ____ times per week
- ____ times per month

15. On average, how much urine do you leak?:

- no leakage
- wets underwear
- wets the floor
- just a few drops
- wets outerwear

16. Do you ever experience:








- difficulty initiating urine stream when ready to empty
- urinary intermittent/slow stream
- weak or intermittent stream
- diarrhea / gas
- painful urination
- sense of not emptying bladder completely
- blood in urine/stool
- itching or burning sensations

Bowel Activity

17. Frequency of bowel movements: ____ times during the
 day week

18. It generally takes me ____ minutes to have a bowel movement, and I: never sometimes often have to strain to empty my bowels.

20. Bristol Stool Form Scale - Please circle which type of stool you most commonly experience:

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

21. If constipation is present, describe management techniques and/ or laxative use:

22. When you have an urge to have a bowel movement, the amount of time you can delay before you have to go to the toilet is:

- ____ minutes
- ____ hours
- none at all

23. Bowel leakage: number of episodes: (please check one)

- no leakage
- ____ times per day
- ____ times per week
- ____ times per month
- only with physical exertion/strong urge

24. On average, how much stool do you lose?:

- no leakage
- stool staining
- small amount in underwear
- complete emptying
- other _____

Other General Health / Bowel / Bladder

25. Any other surgeries or conditions that might affect your current condition: YES NO

If yes, explain _____

26. What form of leakage protection do you wear, and how many changes are required in 24 hours?: (please check one)

- none
- minimal protection; # ____ (tissue paper/paper towel/pantishield)
- moderate protection; # ____ (absorbent product/maxi pad)
- maximum protection; # ____ (special product/diaper)

Diet / Fluids

27. Average fluid intake includes ____ (8 oz) glasses per day, ____ of which are caffeinated or have artificial sweetener.

28. I have been told or suspect that I am intolerant to the following foods / drinks: _____

29. Since the onset of your current symptoms, have you had:

- fever / chills
- unusual fatigue
- nausea
- vomiting
- headaches
- numbness
- numbness in genital / anal areas
- any dizziness or fainting attacks
- unexplained weight change
- malaise--vague feeling of bodily discomfort
- weakness

Medications

List all medications including over-the-counter, vitamins, and supplements.

Med name	Start Date	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the goals you would hope to achieve with physical therapy:
