## MSU Health Care PELVIC HEALTH PATIENT HISTORY

Legal Patient's Name (First, Middle, Last)	Home Therapy: Are you currently receiving health care services in your home that are billed to your insurance? Yes				
Chosen Name:	Pronouns: he/him/his she/her/hers they/them/their				
Other Treatment: Have you received any of these treatments th Chiropractic/Spinal Manipulation OMM (Osteopathic M					
EMAIL: (for exercise program):					
Reason for Visit (Describe Injury): Goal (What do you want	to do better with therapy?): Date of Onset:				
Onset/Timing: 🔲 Number of Prior Episodes:	Gradual Onset Sudden Onset				
How did your pain/problem start?       Unknown       While Lifting       Car Accident       A Fall         Trauma       Overuse       Degenerative Process       Recreation/Sport:       Dental Appt         Pregnancy       Other:       Other:       Other:       Other:					
BLADDER/URINARY QUESTIONS					
BLADDER/ORINARY QUESTIONS         How often do you void during the day/waking hours?         How often do you wake to void/void at night?         < 1 hour					
Is your urine stream: 🗌 weak 🔲 moderate 🗌 strong					
Do you have trouble initiating urine flow: Yes No Sometimes, details:					
Do you every have trouble completely emptying your bladder: Yes No Sometimes, details:					
Do you experience pain while voiding? Yes No	Pain level:/10				
Do you every leak urine: 🗌 Yes 🗌 No	When did the leaking start?				
If yes, please answer a-e; if no please continue after e:					
a) How often do you leak: 1-2 times per day	nth 🔄 a few times per week				
b) When does leaking occur (check all that apply):					
Image: Second control of the second					
c) Are you always aware of the leak 🗌 Yes 🗌 No 📄 sometimes					
<ul> <li>d) What is the volume of leakage (check all that apply):</li> <li>couple of drops couple of tsp large gush full bladder empty</li> </ul>					
e) Do you feel that you have control over leakage?					
How much fluid (oz) do you drink per day?					
How many of the following do you drink per day:        caffeinated beverages      alcohol					
BOWEL/DEFECATION QUESTIONS					
How often do you defecate/poop?					
What is consistency of stool:       hard pellets       soft and forms       loose and watery         Any pair when defeasting?       No.       1000000000000000000000000000000000000					
Any pain when defecating? Yes No	Lowest pain:/10       Highest pain:/10         Rate the level of strain from 0 (no strain) to 10:/10				
Any strain when defecating?       Yes       No       Rate the level of strain from 0 (no strain) to 10:/10         Do you ever feel that you cannot completely empty bowel?       Image: Completely empty bowel?					
	please answer the following) 🗌 No				
	nall amount 🔲 large/full bowel loss				

Are you aware of leak when it occurs? Yes No Any difficulty wiping/getting clean? Yes No			
Do you use a stool or Squatty Potty? Yes No			
How is your diet? (include # of services of fruits/veggies, sources of fiber)			
Any special concerns?			
OTHER:			
Any current low back pain? Yes No Current <b>/10</b> Lowest pain <b>/10</b> Highest pain <b>/10</b>			
If yes, please answer the following (would love the same questions that are on the current intake form)			
Any current mid/upper back pain? Yes No Current/10 Lowest pain/10 Highest pain/10			
Any hip pain? Right Left Both Current <b>/10</b> Lowest pain <b>/10</b> Highest pain <b>/10</b>			
Any tailbone pain? Yes No Current _/10 Lowest pain/10 Highest pain/10			
Any abdominal pain? Yes No Current/10 Lowest pain/10 Highest pain/10			
Any pelvic pain: Yes No			
SITS bones: Current/10 Lowest pain/10 Highest pain/10			
Vulva: Current/10 Lowest pain/10 Highest pain/10			
Urethra: Current/10 Lowest pain/10 Highest pain/10 Current/10 Lowest pain/10 Highest pain/10			
Anus: Current/10 Lowest pain/10 Highest pain/10			
Please map your areas of discomfort or altered			
sensation on the body map.			
XXX = Pain			
000 = Numb/Tingle/Radiating			
*** = Weakness			
Leilen CS			
Aggravating Factors (check all that apply):			
Sitting Going to/raising from sitting Walking Up/Down Stairs Lying Down			
Looking Up Overhead       Reach Overhead       Reach In Front       Reach Behind Back       Reach Across Body         Repetitive Activity       Household Activities       Sports/Recreation       Standing       Squatting			
Sustained Bending Cough Deep Breathing Sleeping Talking Talking			
Chewing Swallowing Yawning Stress			
Other:			

Best       Cold       Hest       Sitting       Standing         Walking       Lying Down       Stretching       Exercise       Massage         MEDICAL/SURGICAL HISTORY:       a. Please check all that apply       Marrier's Disease       Peripheral Vascular         MADS/APH0       Brain Injury       Fifthormyalgia       Lymphedema       Prolapse         ADDS/APH0       Brain Injury       Fifthormyalgia       Merier's Disease       Peripheral Vascular         Andle Symans       Cyclic Fibrosis       Head Injury       Muscle/Bone Problem       Rheurobalical Disorder         Anthel Symans       Cyclic Fibrosis       Head Disasee       Neurobalical Disorder       Sits Sensitivities         Anthel Symans       Cyclic Fibrosis       Heard Disasee       Neurobalical Disorder       Sits Sensitivities         Anthel Syman       Epileps//Seizures       Hypermobility / EDS       Obesity       Urinary Problems         Astimina       Epileps/Seizures       Hypermobility / EDS       Obesity       Urinary Problems         Surgery History: (please fist & indude dates (malyear):       Orthouts       Verigo       Verigo         MEDICATIONS: Do you take prescription or nonprescription medication?       YES, NO If yes, please list below or attach a list.         Prescription       Non-prescription	Alleviating Factors (c	heck all th	nat apply):	Noth	ling	Med	ication	Weari	ng a splint/orthotics	
Walking       Lying Down       Stretching       Exercise       Massage         MEDICAL/SURGICAL HISTORY:       a. Please check all that apply       Prolapse       Prolapse         ADD/ADHO       Brain Injury       Filoromyalgia       Hymphedema       Peripheral Vascular         Altergies/Hayfever       Cancer       Fracture       Menter's Disease       Peripheral Vascular         Altergies/Hayfever       Cancer       Fracture       Mesch Plany       Serious Illness/Injury         Ankle Sprains       Cystic Fibrosis       Head Injury       Muscle/Bone Problem       Returnation of the serious Illness/Injury         Antelex/Deression       Diabetes       Heart Disease       Neuropatry       Stroke         Antelex/Deression       Diabetes       Hernisoin       Otherics       Vertigo         Bakhma       Epilepsy/Seirures       Hypermobility / EDS       Obseily       Urinary Problems         Surgery History: [please itst & include dates (mo/year):       Othorics       Osteoporosis       Perscription         MEDICATIONS: Do you take prescription or nonprescription medication?       YES_ NO If yes, please list below or attach a list.         Prescription       Non-prescription       Coronut	· · ·		11 //			=	-			
MEDICAL/SURGICAL HISTORY: a. Please check all that apply         DAD/ADHO       Brain Injury       Fibromyalgia       Lymphedema       Prolapse         DADS/ADHO       Brain Injury       Fibromyalgia       Lymphedema       Prolapse         DADS/HIW       Cancer       Practure       Mener's Disease       Peripheral Vacular         Ankle Sprains       Cystic Fibrosis       Headaches       Neuropalty       Serious Illness/Injury         Ankley Sprains       Cystic Fibrosis       Heart Disease       Neuropathy       Storike         Anther Sprains       Edoometriosis       Hypermobility / EDS       Obesity       Urinary Problems         Anther Sprains       Edoometriosis       Hypermobility / EDS       Othotics       Vertigo         Back Pain       Falls       Interstital Cysts       Osteoporosis       Vertigo         Bleeding Disorder       Fibroids       Lung Disease       PCOS       Sturgery History: (please list below or attach a list.         Prescription       Non-prescription       Non-prescription       Coconut       pine/linden         ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         ALLERGIES: Do you have any allergies?       None       Bees       Latex	Walking	Lying I	Down			=	-		-	
ADD/ADHO       Brain Injury       Fibromyalgia       Lymphedema       Prolapse         AIDS/HIV       Cancer       Meniere's Disease       Peripheral Vacular         AIRS/HIV       Cancer       Meniere's Disease       Peripheral Vacular         Alke Sprains       Cystic Fibrosis       Head injury       Musice/Bone Problem       Rheumatoid Arthritis         Ankylosing spondylitis       Developmental Delay       Heart Disease       Neuropathy       Scrious Illness/Injury         Ankylosing spondylitis       Endometriosis       Hypermobility / EDS       Obesity       Urinary Problems         Asthma       Epilepsy/Seizures       Hypertension       Orthotics       Vertigo         Bleeding Disorder       Fibroid       Lung Disease       PCOS         Surgery History: (please list & include dates (ma/year):       Non-prescription       Interstital Cysts       Osteoporosis         ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):       (We use various emollients and tapes, please feel free discuss ingredients with therapists.)       Social HISTORY:         Somoking Status:       Never       Forntr       Current Everyday       Current Some Day       Smoker - Status Unknown <td>Other:</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	Other:									
ADD/ADHO       Brain Injury       Fibromyalgia       Lymphedema       Prolapse         AIDS/HIV       Cancer       Meniere's Disease       Peripheral Vacular         AIRS/HIV       Cancer       Meniere's Disease       Peripheral Vacular         Alke Sprains       Cystic Fibrosis       Head injury       Musice/Bone Problem       Rheumatoid Arthritis         Ankylosing spondylitis       Developmental Delay       Heart Disease       Neuropathy       Scrious Illness/Injury         Ankylosing spondylitis       Endometriosis       Hypermobility / EDS       Obesity       Urinary Problems         Asthma       Epilepsy/Seizures       Hypertension       Orthotics       Vertigo         Bleeding Disorder       Fibroid       Lung Disease       PCOS         Surgery History: (please list & include dates (ma/year):       Non-prescription       Interstital Cysts       Osteoporosis         ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):       (We use various emollients and tapes, please feel free discuss ingredients with therapists.)       Social HISTORY:         Somoking Status:       Never       Forntr       Current Everyday       Current Some Day       Smoker - Status Unknown <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>										
ADD/ADHO       Brain Injury       Fibromyalgia       Lymphedema       Prolapse         AIDS/HIV       Cancer       Meniere's Disease       Peripheral Vacular         AIRS/HIV       Cancer       Meniere's Disease       Peripheral Vacular         Alke Sprains       Cystic Fibrosis       Head injury       Musice/Bone Problem       Rheumatoid Arthritis         Ankylosing spondylitis       Developmental Delay       Heart Disease       Neuropathy       Scrious Illness/Injury         Ankylosing spondylitis       Endometriosis       Hypermobility / EDS       Obesity       Urinary Problems         Asthma       Epilepsy/Seizures       Hypertension       Orthotics       Vertigo         Bleeding Disorder       Fibroid       Lung Disease       PCOS         Surgery History: (please list & include dates (ma/year):       Non-prescription       Interstital Cysts       Osteoporosis         ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):       (We use various emollients and tapes, please feel free discuss ingredients with therapists.)       Social HISTORY:         Somoking Status:       Never       Forntr       Current Everyday       Current Some Day       Smoker - Status Unknown <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>										
ADD/ADHO       Brain Injury       Fibromyalgia       Lymphedema       Prolapse         AIDS/HIV       Cancer       Meniere's Disease       Peripheral Vacular         AIRS/HIV       Cancer       Meniere's Disease       Peripheral Vacular         Alke Sprains       Cystic Fibrosis       Head injury       Musice/Bone Problem       Rheumatoid Arthritis         Ankylosing spondylitis       Developmental Delay       Heart Disease       Neuropathy       Scrious Illness/Injury         Ankylosing spondylitis       Endometriosis       Hypermobility / EDS       Obesity       Urinary Problems         Asthma       Epilepsy/Seizures       Hypertension       Orthotics       Vertigo         Bleeding Disorder       Fibroid       Lung Disease       PCOS         Surgery History: (please list & include dates (ma/year):       Non-prescription       Interstital Cysts       Osteoporosis         ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):       (We use various emollients and tapes, please feel free discuss ingredients with therapists.)       Social HISTORY:         Somoking Status:       Never       Forntr       Current Everyday       Current Some Day       Smoker - Status Unknown <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>										
DDS/HIV       Cancer       Fracture       Meniere's Disease       Peripheral Vascular         Allergies/Hayfever       Carpal Tunnel       Head Injury       Muscle/Bone Problem       Phenimatoli Arthritis         Ankes/Poinsins       Cystic Fibrosis       Headaches       Neurological Disorder       Skin Sensitivities         Ankes/Poinsins       Developmental Delay       Heart Disease       Neuropathy       Serious illness/Injury         Ankes/Poinsins       Developmental Delay       Heart Disease       Neuropathy       Urinary Problems         Ankeit/Poinsins       Endometricosis       Hypermobility / EDS       Obesity       Urinary Problems         Back Pain       Falls       Intersitial Cysts       Osteoporosis       Vertigo         Bleeding Disorder       Fibroids       Lung Disease       PCOS         Surgery History: (please list & include dates (ma/year):       Non-prescription       Non-prescription         AlLERGIES: Do you take prescription or nonprescription medication?       YES, NO If yes, please list below or attach a list.         Prescription       Non-prescription       Coconut       pine/linden         Adhesive/tapes       Other (please specify):       Social History:       Social History:       Social History:         Smoking Status:       Never       Former       Curr		<u>. HISTORY</u>	a. Please cheo					_		
Ankle Sprains       Carpai Tunnel       Head adves       Neck Injury       Muscle/Bone Problem       Rheumatoid Arthritis         Ankle Sprains       Cystic Fibrosis       Head ches       Neck Injury       Skin Sensitivities         Anklety/Depressin       Diabetes       Hernia       Neuropathy       Stroke         Arthritis       Endometriosis       Hyperrobility / EDS       Obesity       Urinary Problems         Back Pain       Falls       Intervitial Cysts       Octooprosis       Vertigo         Beeding Disorder       Fibroids       Lung Disease       PCOS         Surgery History: (please list & include dates (ma/year):       Non-prescription       Non-prescription         Athenistve/tapes       Other (please specify):       Non-prescription       Coconut       pine/linden         Adhesive/tapes       Other (please specify):       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Melogistatus:       Never       Former       Current Everyday       Current Some Day       Smoker - Status Unknown         Employment/Work (job/school):       Full time       Part time       Retired       Student       Unemployed       Disability         Occupation:       Sports/Hobbies:       Everols       None       Ever			• •	=	, 0	= ' '				
Ankle Sprains       Cystic Fibrosis       Headaches       Neck Injury       Sensitivities         Ankvie Sprains       Developmental Delay       Heart Disease       Neuropathy       Strick         Ankvie Sprains       Developmental Delay       Hernia       Neuropathy       Strick         Ankvie Sprains       Developmental Delay       Hernia       Neuropathy       Strick         Ankvie Sprains       Endometriosis       Hypermobility / EDS       Obesity       Urinary Problems         Asthma       Fibroids       Lung Disease       PCOS       Vertigo         Back Pain       Fibroids       Lung Disease       PCOS         Surgery History: (please list & include dates (mo/year):       Non-prescription       Non-prescription         AtLERGIES: Do you have any allergies?       None       Non-prescription       Coconut       pine/linden         Adhesive/tapes       Otypess, please fiel free discuss ingredients with therapists.)       Social History:       Smoking Status:       Newer       Former       Current Everyday       Current Some Day       Smoker – Status Unknown         Employment/Work (ub/school):       Full time       Part time       Retired       Student       Unemployed       Disability         Occupation:       Sports/Hobbiles:       Sports/Hobbiles: <td< td=""><td></td><td>=</td><td></td><td></td><td></td><td>=</td><td></td><td colspan="2"></td></td<>		=				=				
Anxleylosing spondylitis       Developmental Delay       Heart Disease       Neurological Disorder       Skin Sensitivities         Anxlety/Depression       Diabetes       Herni       Neuropathy       Disobetes         Arthritis       Endometriosis       Hypermobility / EDS       Obesity       Urnary Problems         Asthma       Epilepsy/Seizures       Hypermobility / EDS       Obesity       Urnary Problems         Back Pain       Falls       Interstital Cysts       Octeoporosis       Vertigo         Bleeding Disorder       Fibroids       Lung Disease       PCOS         Surgery History: (please list & include dates (mo/year):       Non-prescription       Non-prescription         MEDICATIONS: Do you take prescription or nonprescription medication?       YES, NO If yes, please list below or attach a list.         Prescription       Non-prescription       Coconut       pine/linden         Adhesive/tapes       Other (please specify):       (We use various emollients and tapes, please feel free discuss ingredients with therapists.)       SOCIAL HISTORY:         SocIAL HISTORY:       Smoking Status:       None       Perture       Current Everyday       Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Pult time       Part time       Retried       Student       Unemployeed <t< td=""><td></td><td>= .</td><td></td><td>=</td><td>• •</td><td colspan="2"></td><td></td><td></td></t<>		= .		=	• •					
□ Anthritis       □ Diabetes       □ Hernia       □ Neuropathy       □ Stroke         □ Arthritis       □ Endometriosis       □ Hypertension       ○ Othotics       ○ Vertigo         □ Back Pain       □ Falls       □ Intersitial Cysts       ○ Osteoporosis       ○ Vertigo         □ Bleeding Diorder       □ Fibroids       □ Lung Disease       ○ PCOS         □ Surgery History: (please list & include dates (mo/year):       □ Ostoner       ○ PCOS         ■ MEDICATIONS: Do you take prescription or nonprescription medication?       □ YES, □ NO. If yes, please list below or attach a list.         Prescription       Non-prescription       □ On-prescription         ALLERGIES: Do you have any allergies?       □ None       □ Bees       □ Latex       □ Perfumes/lotions       □ Coconut       □ pine/linden         △ Adhesive/tapes       □ Other (please specify):       □ Non-prescription       □ Ostoner       □ Sotoler       □ pine/linden         SOCIAL HISTORY:       □ Sonoker - Status Unknown       □ Current Everyday       □ Current Some Day       □ Smoker - Status Unknown         Employment/Work (uok/school):       □ Full time       □ Part time       □ Retired       □ Student       □ Unemployed       □ Disability         Occupation:       □ Soparts/Hobbies:       □ Sports/Hobbies:       □ Student       □ Unemployed<		= '				=		=		
□ Arthritis       □ Endometriosis       □ Hypermobility / EDS       □ Obesity       □ Urinary Problems         □ Asthma       □ Epilepsy/Seizures       □ Hypermobility / EDS       □ Orthotics       □ Vertigo         □ Back Pain       □ Falls       □ Intersitial Cysts       □ Osteoporosis       □ Vertigo         □ Bleeding Disorder       □ Fibroids       □ Lung Disease       □ PCOS         □ Surgery History: (please list & include dates (mo/year):       □ Non-prescription         ■ ALLERGIES: Do you take prescription or nonprescription medication?       □ YES, □ NO If yes, please list below or attach a list.         Prescription       Non-prescription         ALLERGIES: Do you have any allergies?       None       □ Bees       □ Latex       □ Perfumes/lotions       □ Coconut       □ pine/linden         □ Adhesive/tapes       □ Other (please specify):       □       □       □       □       □         (We use various emollients and tapes, please feel free discuss ingredients with therapists.)       SOCIAL HISTORY:       □ </td <td></td> <td>=</td> <td>-</td> <td></td> <td></td> <td>=</td> <td colspan="2">—</td> <td></td>		=	-			=	—			
Asthma       Epilepsy/Seizures       Hypertension       Orthotics       Vertigo         Back Pain       Falls       Intersitial Cysts       Osteoprosis         Bleeding Disorder       Fibroids       Lung Disease       PCOS         Surgery History: (please list & include dates (mo/year):       Non-prescription       PCOS         MEDICATIONS: Do you take prescription or nonprescription medication?       YES, NO. If yes, please list below or attach a list.         Prescription       Non-prescription       Non-prescription         ALLERGIES: Do you have any allergies?       Non       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):       Social History:       Social History:       Somoking Status:       Never       Former       Current Everyday       Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Full time       Part time       Retired       Student       Unemployed       Disability         Occupation:       Sports/Hobbies:       Sports/Hobbies:       Exercise Level:       None       Doccasional       Moderate       Heavy       Heavy       Humpleyded exercise, days/wk, and average # minutes)         Marital Status:       Alone       Live with others       Bigle-level work       M					-	=				
Back Pain       Falls       Intersitial Cysts       Osteoporosis         Bleeding Disorder       Fibroids       Lung Disease       PCOS         Surgery History: (please list & include dates (ma/year):         MEDICATIONS: Do you take prescription or nonprescription medication?       YES, NO If yes, please list below or attach a list.         Prescription       Non-prescription         ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):		=		=	-	=	· ·			
Bleeding Disorder       Fibroids       Lung Disease       PCOS         Surgery History: (please list & include dates (mo/year):         MEDICATIONS: Do you take prescription or nonprescription medication?       YES, NO If yes, please list below or attach a list.         Prescription       Non-prescription         ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):		= · ·	397 301201 03						0	
Surgery History: (please list & include dates (mo/year):         MEDICATIONS: Do you take prescription or nonprescription medication? [_YES,NO_If yes, please list below or attach a list.         Prescription         ALLERGIES: Do you have any allergies?NoneBeesLatexPerfumes/lotionsCoconutpine/lindenAdhesive/tapesOther (please specify):         (We use various emollients and tapes, please feel free discuss ingredients with therapists.)         SOCIAL HISTORY:         Smoking Status:NeverFormerCurrent EverydayCurrent Some DaySmoker - Status Unknown         Employment/Work (job/school):Full timePart timeRetiredStudentUnemployedDisability         Occupation:			45	=	•		-			
MEDICATIONS: Do you take prescription or nonprescription medication?       YES, NO If yes, please list below or attach a list.         Prescription       Non-prescription         ALLERGIES: Do you have any allergies?       None         Adhesive/tapes       Other (please specify):         (We use various emollients and tapes, please feel free discuss ingredients with therapists.)       Social History:         SOCIAL HISTORY:       Smoking Status:       Never         Smoking Status:       Never       Former         Current Everyday       Current Some Day       Smoker - Status Unknown         Employment/Work (job/school):       Full time       Part time         Sports/Hobbies:       Exercise Level:       None       Occasional         Marital Status:       Unknown       Married       Single         Marital Status:       Alone       Live with others       Pet(s): (please specify)         Single/Multi-level home       Multi-level home       Multi-level work       Multi-level work         Able to care for self:       Yes       No       Mo       Multi-level work         Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/railbone?       Yes       No					Discuse					
Prescription       Non-prescription         ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):         (We use various emollients and tapes, please feel free discuss ingredients with therapists.)         SOCIAL HISTORY:         Smoking Status:       Never       Former       Current Everyday       Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Full time       Part time       Retired       Student       Unemployed       Disability         Occupation:       Sports/Hobbies:       Sports/Hobbies:       Sports/Hobbies:       Sports/Hobbies:       Sports/Hobbies:         Exercise Level:       Non       Occasional       Moderate       Heavy       Heavy       Please include type of exercise, days/wk, and average # minutes)         Marital Status:       Unknown       Married       Domestic Partner       Divorced       # of Children:       Single-level home       Single-level home       Single-level work       Multi-level work       Able to care for self:       Yes       No (if no, who cares for you?)         Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?       Yes       No<										
Prescription       Non-prescription         ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):         (We use various emollients and tapes, please feel free discuss ingredients with therapists.)         SOCIAL HISTORY:         Smoking Status:       Never       Former       Current Everyday       Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Full time       Part time       Retired       Student       Unemployed       Disability         Occupation:       Sports/Hobbies:       Sports/Hobbies:       Sports/Hobbies:       Sports/Hobbies:       Sports/Hobbies:         Exercise Level:       Non       Occasional       Moderate       Heavy       Heavy       Please include type of exercise, days/wk, and average # minutes)         Marital Status:       Unknown       Married       Domestic Partner       Divorced       # of Children:       Single-level home       Single-level home       Single-level work       Multi-level work       Able to care for self:       Yes       No (if no, who cares for you?)         Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?       Yes       No<										
Prescription       Non-prescription         ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):         (We use various emollients and tapes, please feel free discuss ingredients with therapists.)         SOCIAL HISTORY:         Smoking Status:       Ner       Former       Current Everyday       Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Full time       Part time       Retired       Student       Unemployed       Disability         Occupation:       Sports/Hobbies:       Sports/Hobbies:       Sports/Hobbies:       Sports/Hobbies:         Exercise Level:       Non       Occasional       Moderate       Heavy       Heavy         (Please include type of exercise, days/wk, and average # minutes)       Divorced       # of Children:       Sports/Hobbies:         Marital Status:       Unknown       Maried       Done       Donestic Partner       Single-Ievel home       Single-Ievel work       Multi-level work         Able to care for self:       Yes       No (if no, who cares for you?)       Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?       Yes <td< td=""><td>MEDICATIONS: Do vo</td><td>ou take presi</td><td>ription or nonr</td><td>prescriptio</td><td>n medication?</td><td></td><td>NO If yes please li</td><td>ist below</td><td>or attach a list</td></td<>	MEDICATIONS: Do vo	ou take presi	ription or nonr	prescriptio	n medication?		NO If yes please li	ist below	or attach a list	
ALLERGIES: Do you have any allergies?       None       Bees       Latex       Perfumes/lotions       Coconut       pine/linden         Adhesive/tapes       Other (please specify):         (We use various emollients and tapes, please feel free discuss ingredients with therapists.)         SOCIAL HISTORY:         Smoking Status:       Never       Former       Current Everyday       Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Full time       Part time       Retired       Student       Unemployed       Disability         Occupation:       Sports/Hobbies:       Student       Unemployed       Disability         Occupation:       Separated       Moderate       Heavy         (Please include type of exercise, days/wk, and average # minutes)       Single       Divorced       # of Children:         Separated       Widowed       Domestic Partner       Living Status:       Alone       Live with others       Pet(s): (please specify)         Single/Multi-level home/work:       Single-level home       Multi-level home       Single-level work       Multi-level work         Able to care for self:       Yes       No       No       To average Amounted touching, assault, falls onto pelvis/tailbone?       Yes       No         If so, do you feel comfortable givin	· · ·									
Adhesive/tapes       Other (please specify):         (We use various emollients and tapes, please feel free discuss ingredients with therapists.)         SOCIAL HISTORY:         Smoking Status:       Never         Former       Current Everyday         Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Full time         Part time       Retired         Student       Unemployed         Disability         Occupation:       Sports/Hobbies:         Exercise Level:       None         Occasional       Moderate         Heavy       (Please include type of exercise, days/wk, and average # minutes)         Marital Status:       Unknown         Married       Single         Divorced       # of Children:         Separated       Widowed         Domestic Partner       Living Status:         Living Status:       Alone         Live with others       Pet(s): (please specify)         Single/Multi-level home/work:       Single-level home         Able to care for self:       Yes         Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?         Yes       No					_	P P				
Adhesive/tapes       Other (please specify):         (We use various emollients and tapes, please feel free discuss ingredients with therapists.)         SOCIAL HISTORY:         Smoking Status:       Never         Former       Current Everyday         Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Full time         Part time       Retired         Student       Unemployed         Disability         Occupation:       Sports/Hobbies:         Exercise Level:       None         Occasional       Moderate         Heavy       (Please include type of exercise, days/wk, and average # minutes)         Marital Status:       Unknown         Married       Single         Divorced       # of Children:         Separated       Widowed         Domestic Partner       Living Status:         Living Status:       Alone         Live with others       Pet(s): (please specify)         Single/Multi-level home/work:       Single-level home         Able to care for self:       Yes         Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?         Yes       No										
Adhesive/tapes       Other (please specify):         (We use various emollients and tapes, please feel free discuss ingredients with therapists.)         SOCIAL HISTORY:         Smoking Status:       Never         Former       Current Everyday         Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Full time         Part time       Retired         Student       Unemployed         Disability         Occupation:       Sports/Hobbies:         Exercise Level:       None         Occasional       Moderate         Heavy       (Please include type of exercise, days/wk, and average # minutes)         Marital Status:       Unknown         Married       Single         Divorced       # of Children:         Separated       Widowed         Domestic Partner       Living Status:         Living Status:       Alone         Live with others       Pet(s): (please specify)         Single/Multi-level home/work:       Single-level home         Able to care for self:       Yes         Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?         Yes       No	ALLERGIES: Do you ha	ve anv aller	vies? 🗌 None	Bee	s 🗍 Latex	Perfum	es/lations Co		nine/linden	
(We use various emollients and tapes, please feel free discuss ingredients with therapists.)         SOCIAL HISTORY:         Smoking Status:       Never         Former       Current Everyday       Current Some Day         Smoking Status:       Never         Full time       Part time         Retired       Student       Unemployed         Occupation:       Sports/Hobbies:         Exercise Level:       None       Occasional         Moderate       Heavy         (Please include type of exercise, days/wk, and average # minutes)         Marital Status:       Unknown         Separated       Widowed       Domestic Partner         Living Status:       Alone       Live with others       Pet(s): (please specify)         Single/Multi-level home/work:       Single-level home       Multi-level home       Single-level work         Able to care for self:       Yes       No       Mo       Multi-level work         Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?       Yes       No		-							j pine/inden	
SOCIAL HISTORY:         Smoking Status:       Never       Former       Current Everyday       Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Full time       Part time       Retired       Student       Unemployed       Disability         Occupation:       Sports/Hobbies:       Sports/Hobbies:       Sports/Hobbies:       Student       Unemployed       Disability         Exercise Level:       None       Occasional       Moderate       Heavy       (Please include type of exercise, days/wk, and average # minutes)         Marital Status:       Unknown       Married       Single       Divorced       # of Children:         Separated       Widowed       Domestic Partner       Ivertion       Single-level home       Multi-level home         Living Status:       Alone       Live with others       Pet(s): (please specify)       Single-level work       Able to care for self:       Yes       No (if no, who cares for you?)         Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?       Yes       No         If so, do you feel comfortable giving more details to your therapist today?       Yes       No			specify).							
SOCIAL HISTORY:         Smoking Status:       Never       Former       Current Everyday       Current Some Day       Smoker – Status Unknown         Employment/Work (job/school):       Full time       Part time       Retired       Student       Unemployed       Disability         Occupation:       Sports/Hobbies:       Sports/Hobbies:       Sports/Hobbies:       Student       Unemployed       Disability         Exercise Level:       None       Occasional       Moderate       Heavy       (Please include type of exercise, days/wk, and average # minutes)         Marital Status:       Unknown       Married       Single       Divorced       # of Children:         Separated       Widowed       Domestic Partner       Ivertion       Single-level home       Multi-level home         Living Status:       Alone       Live with others       Pet(s): (please specify)       Single-level work       Able to care for self:       Yes       No (if no, who cares for you?)         Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?       Yes       No         If so, do you feel comfortable giving more details to your therapist today?       Yes       No										
Smoking Status: Never Former Current Everyday Current Some Day Smoker – Status Unknown   Employment/Work (job/school): Full time Part time Retired Student Unemployed Disability   Occupation: Sports/Hobbies:   Exercise Level: None Occasional Moderate Heavy   (Please include type of exercise, days/wk, and average # minutes)   Marital Status:   Unknown Married Single Divorced # of Children:   Separated Widowed Domestic Partner Pet(s): (please specify)   Single/Multi-level home Single-level home Single-level work Multi-level work   Able to care for self: Yes No No If so, do you feel comfortable giving more details to your therapist today? Yes No	(We use various emollier	nts and tape	s, please feel fre	ee discuss	ingredients wi	th therapist	s.)			
Employment/Work (job/school): Full time Part time Retired Student Unemployed Disability   Occupation: Sports/Hobbies:   Exercise Level: None Occasional Moderate Heavy (Please include type of exercise, days/wk, and average # minutes) Marital Status: Unknown Married Single Divorced # of Children: Separated Widowed Domestic Partner Living Status: Alone Live with others Pet(s): (please specify) Single/Multi-level home/work: Single-level home Multi-level home Single-level work Multi-level work Multi-level work Mo (if no, who cares for you?) Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone? Yes No	SOCIAL HISTORY:									
Occupation: Sports/Hobbies:   Exercise Level: None Occasional Moderate Heavy (Please include type of exercise, days/wk, and average # minutes) Marital Status: Unknown Married Single Divorced # of Children: Separated Widowed Domestic Partner Living Status: Alone Live with others Pet(s): (please specify) Single-level home/work: Single-level home Multi-level home Single-level work Multi-level work Mo If so, do you feel comfortable giving more details to your therapist today? Yes No	Smoking Status: 🗌 N	lever	Former	Curr	ent Everyday	Curre	ent Some Day	Smoke	er – Status Unknown	
Exercise Level: None Occasional Moderate Heavy   (Please include type of exercise, days/wk, and average # minutes)     Marital Status: Unknown Married Single Divorced # of Children:   Separated Widowed Domestic Partner   Living Status: Alone Live with others Pet(s): (please specify)   Single/Multi-level home/work: Single-level home Multi-level home Single-level work   Able to care for self: Yes No   Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?   Yes No	Employment/Work (job/so	chool):	Full time	🗌 Part	time 🗌 Re	etired	Student	Unem	ployed 🗌 Disability	
(Please include type of exercise, days/wk, and average # minutes)     Marital Status:   Unknown   Married   Single   Domestic Partner     Living Status:   Alone   Live with others   Pet(s):   (please specify)   Single-level home   Single/Multi-level home/work:   Single-level home   Multi-level home   Single-level home   Multi-level work   Able to care for self:   Yes   No   If so, do you feel comfortable giving more details to your therapist today?	Occupation:				Spor	ts/Hobbies:				
(Please include type of exercise, days/wk, and average # minutes)     Marital Status:   Unknown   Married   Single   Domestic Partner     Living Status:   Alone   Live with others   Single/Multi-level home/work:   Single-level home   Multi-level home   Single-level home   Multi-level home   Single-level work   Able to care for self:   Yes   No   If so, do you feel comfortable giving more details to your therapist today?										
Marital Status: Unknown Married Single Divorced # of Children:   Separated Widowed Domestic Partner Pet(s): (please specify)   Living Status: Alone Live with others Pet(s): (please specify)   Single/Multi-level home/work: Single-level home Multi-level home Single-level work   Able to care for self: Yes No (if no, who cares for you?)   Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone? Yes No If so, do you feel comfortable giving more details to your therapist today? Yes No										
Separated Widowed Domestic Partner   Living Status: Alone Live with others Pet(s): (please specify)   Single/Multi-level home/work: Single-level home Multi-level home Single-level work   Able to care for self: Yes No (if no, who cares for you?)   Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?   Yes No   If so, do you feel comfortable giving more details to your therapist today?   Yes No	(Please include type of exercise, days/wk, and average # minutes)									
Separated Widowed Domestic Partner   Living Status: Alone Live with others Pet(s): (please specify)   Single/Multi-level home/work: Single-level home Multi-level home Single-level work   Able to care for self: Yes No (if no, who cares for you?)   Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?   Yes No   If so, do you feel comfortable giving more details to your therapist today?   Yes No										
Separated Widowed Domestic Partner   Living Status: Alone Live with others Pet(s): (please specify)   Single/Multi-level home/work: Single-level home Multi-level home Single-level work   Able to care for self: Yes No (if no, who cares for you?)   Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?   Yes No   If so, do you feel comfortable giving more details to your therapist today?   Yes No	Marital Status: 11n	known	Married	Sing		ivorced	# of Children:			
Living Status: Alone   Live with others Pet(s): (please specify)   Single/Multi-level home/work: Single-level home Multi-level home Single-level work Multi-level work			=	= -		Worceu	# of children.			
Single/Multi-level home/work: Single-level home Multi-level home Single-level work Multi-level work   Able to care for self: Yes Yes No If so, do you feel comfortable giving more details to your therapist today? Yes No							Pet(s): (please spec	ify)		
Able to care for self:       Yes       No (if no, who cares for you?)         Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone?       Yes       No         If so, do you feel comfortable giving more details to your therapist today?       Yes       No		/work:	Single-level h	nome	Multi-level	home		-	Multi-level work	
Do you have a history of trauma or abuse including physical abuse, emotional/relationship abuse, unwanted touching, assault, falls onto pelvis/tailbone? Yes No If so, do you feel comfortable giving more details to your therapist today? Yes No								<b>F</b>		
assault, falls onto pelvis/tailbone? Yes No If so, do you feel comfortable giving more details to your therapist today? Yes No										
assault, falls onto pelvis/tailbone? Yes No If so, do you feel comfortable giving more details to your therapist today? Yes No	Do you have a history	of trauma	or abuse inclu	uding phy	/sical abuse, e	emotional/	relationship abu	se, unwa	anted touching,	
If so, do you feel comfortable giving more details to your therapist today? Yes No				_	· · · · ·	-		-	-	
Do you feel safe at home? Yes No	If so, do you feel comf	fortable giv	ving more deta	ails to yo	ur therapist t	oday? 🗌 '	Yes 🗌 No			



## PELVIC FLOOR – VAGINAL INTAKE FORM

Patient's Name:				
Chosen Name:	Pronouns: he/him/his she/her/hers they/them/their			
VAGINAL QUESTIONS:				
Any current pain with tampon use? Yes/10	No pain I don't use tampons			
, , , <u> </u>	Yes pain/10			
If pain present, how long does it last after exam is o	complete?			
Are you currently sexually active?	No How many partners?			
Penetrative intercourse? Yes No	Sometimes			
Pain with penetration could be described as:				
Superficial (right at vaginal opening) Lo	west pain/10 Highest pain/10 Duration:			
Deep Lo	west pain/10 Highest pain/10 Duration:			
My pain is described as (please check all th				
tight burningtearing/				
Do you ever experience a bulge at your vaginal ope				
Do you every have vaginal/perineal heaviness or pr	ressure? Yes No			
If yes, what makes the bulge/pressure better?				
What makes it worse?				
	Any nain during or ofter organized Vec.			
Do you orgasm? Yes No	Any pain during or after orgasm? Yes No			
MENSTRUATION HISTORY:				
Age of onset:				
Do you feel your periods are/were: 🗌 fairly regula	r with low levels of pain 🔲 irregular and/or extremely painful			
Did you every miss school/work due to period pain?  Yes No				
Are you currently on any birth control? Yes No Type:				
Age of menopause (if appropriate):				
OBSTETRIC HISTORY:	Ture of doliners (a), the functional doliners the f			
# of pregnancies # of live birth	ns Type of delivery(s): # of vaginal delivery # of C- section			
Any complications with deliveries? (check all that apply)				
prolonged pushing episiotomy tearing vacuum/forcep assisted Other:				
Do you feel that you healed well after delivery?				