Lewis Pelvic Floor Therapy

REBALANCING THE FLOOR OF YOUR CORE

Patient History

Name _____ **Age**_____ **Date**_____

1. Describe the current problem that brought you here?

   _____

2. When did your problem first begin? _____ months ago or years ago.
3. Was your first episode of the problem related to a specific incident?

   Please describe _____

   Specify date_____
4. Since that time is it: staying the ☐ same ☐ getting worse ☐ getting better

   Why or how?_____
5. If pain is present rate pain on a 0-10 scale 10 being the worst._____

   Describe the nature of the pain (i.e., constant burning, intermittent ache)

   _____
6. Describe previous treatment/exercises

   _____
7. Activities/events that cause or aggravate your symptoms. Check all that apply

   ☐ Sitting greater than_____ minutes
   ☐ Walking greater than ____minutes
   ☐ Standing greater than ___ minutes
   ☐ Changing positions (ie. - sit to stand)
   ☐ Light activity (light housework)
   ☐ Vigorous activity/exercise (run/weight lift/jump)
   ☐ Sexual activity
   ☐ With cough/sneeze/straining
   ☐ With laughing/yelling
   ☐ With lifting/bending
   ☐ With cold weather
   ☐ With triggers -running water/key in door
   ☐ With nervousness/anxiety
   ☐ No activity affects the problem

   Other, please list _____
8. What relieves your symptoms?
9. How has your lifestyle/quality of life been altered/changed because of this problem?

   Social activities (exclude physical activities), specify _____

   Diet /Fluid intake, specify _____

   Physical activity, specify _____

   Work, specify _____

   Other _____
10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst
11. What are your treatment goals/concerns?

    _____

Since the onset of your current symptoms have you had:

☐ Fever/Chills
☐ Unexplained weight change
☐ Dizziness or fainting
☐ Change in bowel or bladder functions
☐ Malaise (Unexplained tiredness)
☐ Unexplained muscle weakness
☐ Night pain/sweats
☐ Numbness / Tingling

Other /describe _____

Page 2 History **Name**_____

Health History: Date of Last Physical Exam _____ Tests performed

_____

General Health: ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor Occupation _____
Hours/week _____ On disability or leave? Yes Activity Restrictions? No
Mental Health: Current level of stress ☐ High ☐ Med ☐ Low Current psych therapy? No
Activity/Exercise: ☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5+ days/week
Describe: _____

Have you ever had any of the following conditions or diagnoses? circle all that apply /describe

☐ Cancer	☐ Stroke	☐ Emphysema/chronic bronchitis
☐ Heart problems	☐ Epilepsy/seizures	☐ Asthma
☐ High Blood Pressure	☐ Multiple sclerosis	☐ Allergies-list below
☐ Ankle swelling	☐ Head Injury	☐ Latex sensitivity
☐ Anemia	☐ Osteoporosis	☐ Hypothyroid/ Hyperthyroid
☐ Low back pain	☐ Chronic Fatigue Syndrome	☐ Headaches
☐ Sacroiliac/Tailbone pain	☐ Fibromyalgia	☐ Diabetes
☐ Alcoholism/Drug problem	☐ Arthritic conditions	☐ Kidney disease
☐ Childhood bladder problems	☐ Stress fracture	☐ Irritable Bowel Syndrome
☐ Depression	☐ Rheumatoid Arthritis	☐ Hepatitis HIV/AIDS
☐ Anorexia/bulimia	☐ Joint Replacement	☐ Sexually transmitted disease
☐ Smoking history	☐ Bone Fracture	☐ Physical or Sexual abuse
☐ Vision/eye problems	☐ Sports Injuries	☐ Raynaud's (cold hands and feet)
☐ Hearing loss/problems	☐ TMJ/ neck pain	☐ Pelvic pain

Other/Describe

Surgical /Procedure History

☐ Surgery for your back/spine	☐ Surgery for your bladder/prostate
☐ Surgery for your brain	☐ Surgery for your bones/joints
☐ Surgery for your female organs	☐ Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History (females only)

☐ Childbirth vaginal deliveries #_____	☐ Vaginal dryness
☐ Episiotomy #_____	☐ Painful periods
☐ C-Section #_____	☐ Menopause - when? _____
☐ Difficult childbirth #_____	☐ Painful vaginal penetration
☐ Prolapse or organ falling out	☐ Pelvic pain

Other /describe _____

Males only

☐ Prostate disorders	☐ Erectile dysfunction
☐ Shy bladder	☐ Painful ejaculation
☐ Pelvic pain	

Other /describe _____

Medications - pills, injection, patch	**Start date**	**Reason for taking**

Over the counter -vitamins etc	**Start date**	**Reason for taking**

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

- ☐ Trouble initiating urine stream
- ☐ Urinary intermittent /slow stream
- ☐ Trouble emptying bladder
- ☐ Difficulty stopping the urine stream
- ☐ Trouble emptying bladder completely
- ☐ Straining or pushing to empty bladder
- ☐ Dribbling after urination
- Constant urine leakage
- Other/describe _____

- ☐ Blood in urine
- ☐ Painful urination
- ☐ Trouble feeling bladder urge/fullness
- ☐ Current laxative use
- ☐ Trouble feeling bowel/urge/fullness
- ☐ Constipation/straining
- ☐ Trouble holding back gas/feces
- ☐ Recurrent bladder infections

1. Frequency of urination: awake hour's ____ times per day, sleep hours ___ times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
_____minutes _____hours, ☐ not at all
3. The usual amount of urine passed is: ☐ small ☐ medium ☐ large.
4. Frequency of bowel movements _____ times per day, _____times per week, or _____.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
_____ minutes, _____ hours, ☐ not at all.
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated?_____ glasses per day.
8. Rate a feeling of organ *"falling out"* / prolapse or pelvic heaviness/pressure:
   - ☐ None present
   - ☐ Times per month (specify if related to activity or your period)
   - ☐ With standing for _____ minutes or _____hours.
   - ☐ With exertion or straining

   Other_____

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes

- ☐ No leakage
- ☐ Times per day
- ☐ Times per week
- ☐ Times per month
- ☐ Only with physical exertion/cough

9b. Bowel leakage - number of episodes

- ☐ No leakage
- ☐ Times per day
- ☐ Times per week
- ☐ Times per month
- ☐ Only with exertion/strong urge

10a. On average, how much urine do you leak?

- ☐ No leakage
- ☐ Just a few drops
- ☐ Wets underwear
- ☐ Wets outerwear
- ☐ Wets the floor

10b. How much stool do you lose?

- ☐ No leakage
- ☐ Stool staining
- ☐ Small amount in underwear
- ☐ Complete emptying

11. What form of protection do you wear? (Please complete only one)
   - ☐ None
   - ☐ Minimal protection (Tissue paper/paper towel/pantishields)
   - ☐ Moderate protection (absorbent product, maxipad)
   - ☐ Maximum protection (Specialty product/diaper)
   - Other_____

On average, how many pad/protection changes are required in 24 hours? _____# of pads