

## PELVIC FLOOR REHABILITATION INTAKE SUMMARY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Describe the problem that brings you to therapy: \_\_\_\_\_

Date problem began: \_\_\_\_\_

What is your goal for therapy? \_\_\_\_\_

Do you have pain?  No  Yes, please describe \_\_\_\_\_

Have you had any tests recently? (X-Ray, MRI, CT Scan, etc.) \_\_\_\_\_

Describe what you do to keep physically fit: \_\_\_\_\_

Do you live with:  Spouse  Child(ren)  Parent(s)/Guardian  Alone  Other: \_\_\_\_\_

Are you currently working?  No  Yes, occupation: \_\_\_\_\_

Is there anything else you think your therapist will need to know?: \_\_\_\_\_

**Do you have any difficulty with or are you compensating for any of the following activities?**

Dressing:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hygiene (bathing, toileting, grooming):	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Walking:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Household activities:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Sitting:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Work activities:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Sleeping:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Skills with dominant arm:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Sexual Intercourse	<input type="checkbox"/> No	<input type="checkbox"/> Yes... with penetration?	<input type="checkbox"/> No	<input type="checkbox"/> Yes; and/or 2) with thrust?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

**Do you have any previous history or currently have any of the following conditions?**

Pelvic or tailbone trauma:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hemorrhoids / Fissures:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Currently sexually active:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Irritable Bowel Syndrome:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sexually Transmitted Disease:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Fibroids / Cysts:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Frequent Bladder Infections:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Endometriosis:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Frequent Yeast Infections:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Inflammatory Bowel Disease:	<input type="checkbox"/> No	<input type="checkbox"/> Yes

**Obstetric History**

Date of Delivery or Miscarriage	Time Spent Pushing	Vaginal or Cesarean	Baby's Weight	Trauma or Complications

**Past Medical History: Do you have any previous history of the following conditions?**

High Blood Pressure:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seizures:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart Condition/Pacemaker:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Severe Emotional Disturbance:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Strokes:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Persistent Night Pain:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cancer:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Broken Bones (Fractures):	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Respiratory Disorders/Short of breath:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Metal Implants:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Excessive Fatigue:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Arthritis:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Frequent/Severe Headaches:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fibromyalgia:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Unexplained Weight Loss/Gain:	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Have you taken steroids for a prolonged period of time?  No  Yes

->->->->-> OVER ->->->->->

09.0209



**MIAMI COUNTY MEDICAL CENTER**  
2100 Baptiste Dr., Paola, KS 66071

**PELVIC FLOOR REHABILITATION  
INTAKE SUMMARY**  
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01/18  
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**MCMC No. 2305**

Place  
Patient Label  
Here

## PELVIC FLOOR REHABILITATION INTAKE SUMMARY

Languages you speak:    English    American Sign Language    Spanish    Other \_\_\_\_\_  
 Preferred language for discussing healthcare:  English    American Sign Language    Spanish    Other \_\_\_\_\_  
 Preferred Mode of communication:    Verbal    Sign Language    Written    Other \_\_\_\_\_

<b>ALLERGIES</b> Do you have any allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	<b>REACTION</b>

<b>OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS</b> Do you have any other diagnoses or significant conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	<b>Staff Use Only</b>		
	Time	Date	Signature

<b>PREVIOUS PROCEDURES / SURGERIES</b> Did you have any other previous procedures / surgeries? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	<b>Staff Use Only</b>		
	Time	Date	Signature

<b>CURRENT MEDICATIONS, INCLUDING HERBALS</b> Are you currently taking any medications, including herbals? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list: <span style="margin-left: 400px;"><input type="checkbox"/> See attached list</span>	<b>Staff Use Only</b>		
	Time	Date	Signature

Do you identify with another gender?    No    Yes, which gender do you identify with? \_\_\_\_\_

*Physical Therapy Patients Only: If I am being evaluated by a Physical Therapist without a physician referral, I understand that any diagnosis made is a therapy diagnosis and not a medical diagnosis.*

I acknowledge that the above is true to the best of my knowledge and am aware that if I miss three scheduled visits within the course of treatment that my treatment may be discontinued per therapist discretion.

Time

Date

Patient Signature

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## PELVIC FLOOR REHABILITATION INTAKE SUMMARY

**If you have any bowel or bladder issues, please answer the following:**

How often do you urinate during the day?

- 1-3 times                       11-15 times  
 4-7 times                       More than 15 times  
 8-10 times

How many times do you urinate at night?

- None / Rarely                   2-3 times  
 Once                                 More than 3 times

How long can you hold urine once you have an urge?

- As long as I need to  
 For about 30 minutes  
 For a few minutes (2-5 minutes)  
 For less than 2 minutes  
 Cannot tell when full

When you urinate, do you feel the amount is:

- Small             Medium             Large

Do you feel you empty your bladder completely?

- No                       Yes

Are you able to stop your flow of urine by squeezing your pelvic floor muscles?

- No                       Yes

Do you have any urinary leakage?

- No                       Yes, frequency occurs...  
\_\_\_\_\_ times per day                  \_\_\_\_\_ times per night  
\_\_\_\_\_ times per week                  \_\_\_\_\_ times per month

How much urine do you lose during an accident?

- A few drops (small amount)  
 Enough to spot clothing (medium amount)  
 Most or all of the bladder (large amount)

What type of protection do you use?

- None  
 Panty liner or minipad, \_\_\_\_\_ changes per day  
 Maxi or bladder pad, \_\_\_\_\_ changes per day  
 Diaper or depends,

Do you have frequent bladder infections?

- No                       Yes

What causes you to lose urine?

- Cough, laugh, or sneeze                   Hand washing  
 Physical activity                               Intercourse  
 Approaching a bathroom  
 Other \_\_\_\_\_

Do you have difficulty during urination?

- Difficulty starting flow                   Straining to finish flow  
 Strong urge/frequency                   Slow, dribbling stream  
 Abnormal Color  
 Other \_\_\_\_\_

How many 8 oz. glasses of water do you drink?

\_\_\_\_\_ glasses per day

Which "bladder irritants" do you consume?                  Quantity

- Alcohol \_\_\_\_\_  
 Caffeinated beverages \_\_\_\_\_  
 Decaffeinated beverages \_\_\_\_\_  
 Chocolate \_\_\_\_\_  
 Citric juices \_\_\_\_\_  
 Alcohol \_\_\_\_\_  
 Alcohol \_\_\_\_\_

Frequency of bowel movements: \_\_\_\_\_

Frequent constipation?                   No                       Yes

Frequent diarrhea?                       No                       Yes

Regular laxative use?                     No                       Yes

Bowel sensation present                   No                       Yes

Describe the shape of your stool: \_\_\_\_\_

Do you have any fecal leakage?

- No                       Yes

Fecal leakage amount:

- Small                   Medium                   Large

Do you wear a pad for this?

- No                       Yes

Do you have any known food allergies or sensitivities?

- None / Unknown                   Gluten  
 Dairy                                   Eggs  
 Soy                                       Artificial dyes / sweeteners  
 Peanuts                               Other: \_\_\_\_\_

Do you experience:

- Frequent Gas                   Abdominal Pain                   Bloating

Please let us know about any other bowel or bladder problems that you are experiencing:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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