MOUNT NITTANY HEALTH

Fitness and Rehabilitation: Pelvic Floor

Name: _____ Date of Birth: _____

Please answer all questions to the best of your ability.

Details will be discussed with your Physical Therapist.

Please explain your main complaint: _____

How long has this been a problem? ☐ < 1 year ☐ 1-3 years ☐ 4-8 years ☐ 8 + years

Have you had any treatment for this issue in the past? ☐ Yes ☐ No

If Yes, What treatments? _____

Bowel Movement:

How often do you have a bowel movement? ☐ 1 or more times per day ☐ Every 2-3 days ☐ 1 time per week or less

Do you have any pain with bowel movements? ☐ Yes ☐ No

Do you hold your breath and bear down to have a bowel movement? ☐ Yes ☐ No

Do you have leakage of fecal matter? ☐ Yes ☐ No

If Yes, smear on underwear, loose or formed? _____

Do you feel like you are fully emptying your bowel? ☐ Yes ☐ No

Urination:

In your waking hours, on average, How many times per day do you urinate? ☐ 4 or less ☐ 5-8 ☐ 9-15

How many times do you typically urinate at night? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 +

Do you have any pain with urination? ☐ Yes ☐ No

Do you have leakage of urine? ☐ Yes ☐ No

What activites cause / increase leakage: ☐ Cough, sneeze, laugh ☐ Bending, reaching ☐ Sit to stand ☐ Lifting

Do you have urine leakage after feeling the urge (unable to hold to get to the bathroom)? ☐ Yes ☐ No

Do you have difficulty starting the urine stream? ☐ Yes ☐ No

Does the urine stream stop and start? ☐ Yes ☐ No

Do you wear pads? ☐ Yes ☐ No If yes, what size/thickness? _____ How many per 24 hours? _____

Do you finish urinating and have dribble afterwards (as you are getting up)? ☐ Yes ☐ No

Do you feel like you are fully emptying your bladder? ☐ Yes ☐ No

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Name: _____ Date of Birth: _____

Pregnancy:

Are you currently pregnant? ☐ Yes ☐ No

Have you given birth to children? ☐ Yes ☐ No

If yes How many? _____ Deliveries: vaginal _____ Deliveries: cesarean _____

Any tears or other difficulties? _____

Lifestyle:

Do you have any pain with sexual relations? ☐ Yes ☐ No

Do you have any pain with pelvic exam? ☐ Yes ☐ No

On an average day, what drinks do you drink and how much of each?
Please use the table below:

Beverages / Drink	Quantity