Welcome! Please fill this out to the best of your ability and return to the front desk. Thank you!

Date: ___________________ Gender: ______________________
When did your symptoms begin?:____
Reason for visit (pain, leakage etc)____
Height: ___________ Weight: __________ Occupation: _______________________________________
Were you scheduled for your evaluation in a timely manner? ❑ Yes ❑ No

Activity	**CURRENT** Rating										
We want to know **your goals** to help us guide your care. Please list important activities that you are unable to do or are having difficulty with. ***WHAT ACTIVITIES DO YOU HAVE DIFFICULTY WITH BECAUSE OF YOUR PROBLEM?***	0 = **Unable** to perform activity						10 = **Able** to perform activity at same level as before injury or problem				
List up to 3 activities below.	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1.											
2.											
3.											

Currently I am experiencing (check all that apply):

❑Fever/chills/sweats
❑Numbness or Tingling
❑Depression
❑Headaches
❑Fatigue
❑Changes in bowel or bladder function
❑Poor balance (falls)
❑Changes in appetite
❑Shortness of breath
❑Nausea /Vomiting
❑Difficulty sleeping
❑Unexplained weight loss
❑Difficulty swallowing
❑Dizziness
❑Increased pain at night
❑Difficulty concentrating, thinking

Please indicate any medical or surgical history we should be aware of:

❑Allergies
❑Arthritis
❑Blood Clots
❑Blood disease
❑Cancer
❑Diabetes
❑Drug-resistant infection
❑Epilepsy/Seizures
❑Fibromyalgia
❑Heart Condition
❑Hernia
❑High Blood Pressure
❑High Cholesterol
❑Kidney Disease/Dialysis
❑Liver disease/Hepatitis
❑Lymphedema
❑Multiple Sclerosis
❑Spinal cord injury
❑Stroke/TIA
❑Thyroid disorder
❑Vision Problems
❑Memory Problems
❑Other:___________________
Do you smoke? ❑Yes No❑

Are you allergic to latex and/or adhesives? ❑Yes No❑

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❑ Blood in the Urine (currently)
❑ Blood in the Stool (currently)
❑ Urinary Tract Infections
❑ Prolapse
❑ Rectocele
❑ Cystocele
❑ Hemorrhoids
❑ Pelvic Inflammatory Disease
❑ Endometriosis
❑ Interstitial Cystitis
❑ Ovarian Cysts
❑ Fibroids
❑ Fecal Incontinence/Leakage

❑ Urinary Incontinence/Leakage
❑ Irritable Bowel Syndrome
❑ Chronic Constipation
❑ Chronic Diarrhea
❑ Pelvic Fractures
❑ Coccyx Fractures
Are you pregnant or attempting? ❑ Yes ❑ No/N/A
Are you breast/chest feeding? ❑Yes ❑No/N/A
Are you pre ❑, post❑, or mid❑ menopause? N/A❑

Are you worried about falls or losing your balance?
❑ Yes ❑ No
How many falls or near-falls have you had in the past 6 months? ___________________________

SURGERIES SURGERY DATE
____
____
____
____
____

Other Special Tests (Specify date, type, results)
____
____

Have you given birth? ❑Yes ❑No **If YES:**
# of vaginal deliveries ______
# of Cesarean deliveries _______
Any complications from childbirth (i.e. episitomies, tearing, prolonged pushing etc)?
____
____
____
Last Pelvic Exam (date)_______________
Last Urinalysis (date)_________________

Bladder questions:

1. How many times do you urinate on an average day? __________________________________
2. How many times do you rise at night to urinate? __________________________________
3. Fluid Intake (non caffeine) ______ oz/day (guess) Caffeinated beverages _________ oz/day (guess)

4. How long can you delay the need to urinate)? (check one)
   ❑Indefinitely
   ❑1+ hours
   ❑½ hour
   ❑15 minutes
   ❑less than 10 minutes
   ❑1-2 minutes
   ❑not at all

5. Do you have any of the following (check all that apply)
   ❑difficulty initiating a stream of urine
   ❑weak, slow or intermittent stream of urine
   ❑no perception of bladder fullness
   ❑difficulty emptying bladder completely
   ❑frequent toileting to avoid leaking
   ❑strong sense of urgency
   ❑dribbling after stream ends
   ❑pain/burning during urination
   ❑blood in urine
   ❑None of these

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6. Do you have leaking of urine? ❑No Yes❑ If YES, what makes it worse?
   - ❑strong urge
   - ❑cough/sneeze/laugh
   - ❑running/jumping
   - ❑standing up/position changes
   - ❑sexual activity
   - ❑Immediately after urinating or bowel movement
   - ❑sound of running water
   - ❑when I first get home
   - ❑ light activity
   - ❑moderate activity
   - ❑ vigorous activity
   - ❑other:_______________________

7. How often do you leak urine?
   - ❑times a day ________
   - ❑times a week _________
   - ❑times a month______
   - ❑other ___________
   - ❑N/A ___________

8. How much urine leaks?
   - ❑few drops
   - ❑wet underwear
   - ❑wet outerwear
   - ❑other_________
   - ❑N/A ___________

9. Do you use protection for urine leaks?
   - ❑No protection
   - ❑Panty liner
   - ❑Menstrual Pad
   - ❑Incontinence Pad
   - ❑Depends

10. Since onset, are your bladder symptoms getting: (Check one)
    - ❑better
    - ❑worse
    - ❑not changing
    - ❑I do not have bladder symptoms

Bowel questions:

1. How often do you have a bowel movement?
   - ❑Every 2+ days
   - ❑Every day
   - ❑1-2x/day
   - ❑3-4x/day
   - ❑More than 4x/day

2. Do you have…? (Check all that apply)
   - ❑Trouble defecating/having to push
   - ❑Difficulty emptying bowels completely
   - ❑No urge to poop/unsure when bowels full
   - ❑Pain/burning during defecation
   - ❑Need to use fingers in vagina or perineum to complete a bowel movement
   - ❑None of these

3. Do you have bowel leakage? ❑No Yes ❑ If YES, what makes it worse?
   - ❑cough/sneeze/laugh
   - ❑strong urge
   - ❑loose stool or diarrhea
   - ❑sexual activity
   - ❑light activity
   - ❑moderate activity
   - ❑vigorous activity
   - ❑diet issues

4. How often do you leak stool?
   - ❑times a day ________
   - ❑times a week _________
   - ❑times a month______
   - ❑N/A

5. How much stool leaks?
   - ❑very small, no underwear stains
   - ❑stained underwear
   - ❑stained outerwear
   - ❑N/A

6. Are you aware when a bowel leak is happening? ❑Yes ❑ No, only notice afterwards ❑ N/A

7. Since onset, are your bowel symptoms getting: (Check one)
❑better
❑worse
❑not changing
❑I do not have bowel symptoms

Other questions:

1. Do you have a sense of heaviness, pressure, or "falling out feeling" in the pelvic area?
❑never
❑yes, sometimes
❑yes, frequently
❑unsure

2. If so, what makes it worse?

❑lifting
❑bowel movement
❑standing
❑squatting
❑physical activity
❑sexual activity
❑ pressure worsening through the day
❑menses
❑other:________________________

3. Are you sexually active? ❑Yes ❑No
4. If No, is pain the reason you do not participate in sexual activity? ❑Yes ❑No (skip to next section)

5. If Yes, do you experience any of the following?
❑pain with penetration
❑pain with orgasm or ejaculation
❑pain due to body position
❑pain after sexual activity (but not during)

6. How long does that pain persist?
❑during activity only
❑1-2 hours afterwards
❑A day or so
❑More than a day

7. Pain associated with sexual activity is located at/in:
❑Abdomen
❑Lower back
❑Vagina
❑Penis
❑Scrotum
❑Other: ____

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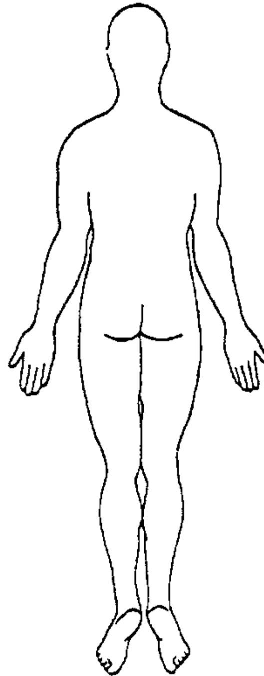
Do you have other pain? ❑No ❑Yes If yes, please complete this section:

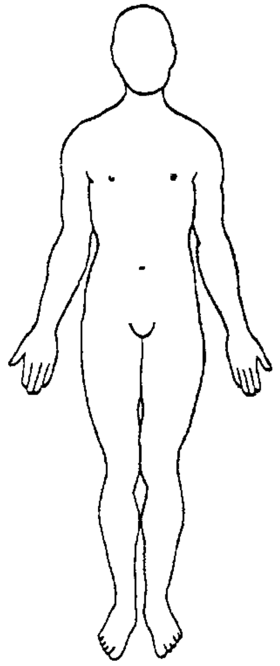
Body Chart:

On the body diagrams to the right, please mark the areas where you have pain:

(Left) – **Back** – (Right)



(Right) –**Front** – (Left)



Circle any/all that apply:
Shooting/sharp pain
Dull/aching pain
Numbness/Tingling

My symptoms currently:
❑ Come and go
❑ Are constant
❑ Are constant, but change with activity

Pain is worse with:
❑physical activity
❑sitting
❑standing
❑laying
❑menustration
❑ other:_______________________

What makes your pain better? _________________________
____
____

Please rate your pain 0-10/10 over the last few days/weeks.
0=no pain, 10=worst pain imaginable.

Pain currently: ______________
Pain at lowest: ______________
Pain at highest: ______________

Do you exercise? If so, what type? ____
What do you do in your free time/what are your hobbies? ____
____
What is a realistic goal that you would like to achieve with therapy?____
____

Is there anything else you would like for us to be aware of?
____
____
____

Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptom scale:
0 = not present
1= not at all
2 = somewhat
3 = moderately
4 = quite a bit

Pelvic Organ prolapse Distress Inventory 6 (POPDI-6)

Do You...	NO	YES
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Total: ___ /6*25=___

Colorectal-Anal distress Inventory 8 (CRAD-8)

Do You...	NO	YES
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Total: ___ /8*25=___

Urinary distress Inventory 6 (UDI-6)

Do You...	NO	YES
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Total: ___ /6*25=___

Scoring the PFDI-20

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

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