OHSUHealth
Hillsboro Medical Center

Patient Identification

Rehabilitation Services Pelvic Intake

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

Date: _____ Start of symptoms: _____

Reason for visit (pain, leakage, etc.): _____

Height: _____ Weight: _____ Occupation: _____

Gender: _____ Pronouns (circle): She/Her He/Him They/Them Other

What do you do in your free time? What is your current exercise routine?_____

_____

What is a realistic goal that you would like to achieve with therapy? _____

_____

Please check any symptoms that you are currently experiencing:

- ☐ Fever/Chills/Sweats
- ☐ Numbness or Tingling
- ☐ Depression
- ☐ Headaches
- ☐ Fatigue
- ☐ Changes in bladder or bowel 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

Are there any surgeries or testing that we should be aware of?

_____

_____

_____

_____

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

- ☐ 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: _____

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

Do you smoke? ☐ Yes ☐ No

Medical History Continued:

- ☐ Blood in the Stool (Currently)
- ☐ Blood in the Urine (Currently)
- ☐ Chronic Constipation
- ☐ Chronic Diarrhea
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Hemorrhoids
- ☐ Interstitial Cystitis
- ☐ Ovarian Cysts
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Prolapse
- ☐ Urinary Tract Infections
- ☐ Fecal Incontinence/Leakage
- ☐ Urinary Incontinence/Leakage
- ☐ Pelvic Fracture(s)
- ☐ Coccyx Fracture(s)

Continued on the next page →

Medical History Cont.:

Are you worried about falling or losing your balance? ☐ Yes ☐ No

How many falls or near-falls have you had in the past 6 months? _____

Do you feel safe in your home? ☐ Yes ☐ No

Do you have a history of sexual abuse or trauma? ☐ Yes ☐ No

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

Have you given birth? ☐ Yes ☐ No

If YES:

# of Vaginal Deliveries: _____

# of Cesarean Deliveries: _____

Did you have any complications from childbirth (i.e., episiotomies, tearing, prolonged pushing, etc.)?_____

Pelvic Floor Disability Index (PDI-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	Symptoms Present?
0 = Not Present	**No**
1 = Not at All	**Yes**
2 = Somewhat	
3 = Moderately	
4 = Quite a Bit	

The survey begins on the next page ⟶

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)		**NO**	**YES**			
1	Do you usually experience pressure in the lower abdomen?	0	1	2	3	4
2	Do you usually experience heaviness or dullness in the pelvic area?	0	1	2	3	4
3	Do you usually have a bulge or something falling out that you can see or feel in your genital region?	0	1	2	3	4
4	Do you ever have to push on the genital region or around the rectum to have or complete a bowel movement?	0	1	2	3	4
5	Do you usually experience a feeling of incomplete bladder emptying?	0	1	2	3	4
6	Do you ever have to push up on a bulge in the genital area with your fingers to start or complete urination?	0	1	2	3	4

Colorectal-Anal Distress Inventory 8 (CRAD-8)		**NO**	**YES**			
7	Do you feel you need to strain too hard to have a bowel movement?	0	1	2	3	4
8	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	0	1	2	3	4
9	Do you usually lose stool beyond your control if your stool is well formed?	0	1	2	3	4
10	Do you usually lose stool beyond your control if your stool is loose?	0	1	2	3	4
11	Do you usually lose gas from the rectum beyond your control?	0	1	2	3	4
12	Do you usually have pain when you pass your stool?	0	1	2	3	4
13	Do you 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

Urinary Distress Inventory 6 (UDI-6)		**NO**	**YES**			
15	Do you usually experience frequent urination?	0	1	2	3	4
16	Do you 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

		NO	YES			
17	Do you usually experience urine leakage related to coughing, sneezing, or laughing?	0	1	2	3	4
18	Do you usually experience small amounts of urine leakage (that is, drops)?	0	1	2	3	4
19	Do you usually experience difficulty emptying your bladder?	0	1	2	3	4
20	Do you usually experience pain or discomfort in the lower abdomen or genital region?	0	1	2	3	4

Additional Bladder Questions:

1. How many times do you urinate on an average day? _____ Night? _____
2. 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
☐ A strong sense of urgency
☐ Dribbling after the stream ends
☐ Pain/burning during urination
☐ Blood in urine
☐ None of these

3. Do you have leaking of urine? ☐ Yes ☐ No
4. How often do you leak urine?

☐ _____ times a day
☐ _____ times a week
☐ _____ times a month
☐ Other: _____
☐ N/A

Additional Bowel Questions:

1. How often do you have a bowel movement? _____
2. Do you have bowel leakage? ☐ Yes ☐ No

Additional Bowel Questions Cont.:

3. Are you aware when a bowel leak is happening?

   ☐ Yes
   ☐ No, I only notice afterward
   ☐ N/A

Other Questions:

1. Do you have pelvic, abdominal, and/or genital pain? ☐ Yes ☐ No
   a. Where is it located?
      ☐ Abdomen
      ☐ Lower back
      ☐ Vagina
      ☐ Penis
      ☐ Scrotum
      ☐ Other: _____
   b. What is the pain on a 0-10 scale? _____
2. Are you sexually active? ☐ Yes ☐ No
3. Do you experience any of the following? (Check all that apply)
   ☐ Pain with penetration ☐ Pain with orgasm or ejaculation
   ☐ Pain due to body position ☐ Pain after sexual activity, but not during
4. Do you have other pain? ☐ Yes ☐ No
   a. If yes, where is it located? _____

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

_____

_____

_____