

**Pelvic Floor Intake Form**

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Occupation \_\_\_\_\_

▪ Referring Doctor \_\_\_\_\_

▪ Other practitioners involved in your care: \_\_\_\_\_

Special Tests for this condition (Pelvic Ultrasound, Urodynamic testing, Defecography etc.):

\_\_\_\_\_

Other health services you have received/are receiving for this condition (chiropractor, acupuncture, prior physical therapy, other medical treatments etc.)

\_\_\_\_\_

Please list all your current prescribed medications, over the counter medications, vitamins, herbs, supplements, and home remedies:

\_\_\_\_\_

\_\_\_\_\_

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**Female Medical History:**

Number of Births: # \_\_\_\_\_

Number of pregnancies: # \_\_\_\_\_

Birth Control: Y N Type \_\_\_\_\_

Hormone Replacement Therapy: Y N

Type and dates of use: \_\_\_\_\_

Date of Menopause Onset: \_\_\_\_\_

Issues with sexual function: Y N

History of Sexual Trauma: Y N

Other significant medical history:

\_\_\_\_\_

\_\_\_\_\_

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**Male Medical History**

History of Prostate Cancer: Y N

If yes what type of treatment:

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Injury to testicles, groin or penis: Y N

If yes describe:

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Issues with sexual function: Y N

History of Sexual Trauma: Y N

Other significant medical history:

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Please circle any of the following issues you experience:

Urinary Leakage

Fecal Leakage

Feeling of heaviness or dropping in pelvis / vagina

Urinary Frequency

Fecal Frequency

Pain with vaginal insertion (gynecological exam, tampons use, intercourse)

Constipation

Pelvic Pain:

Describe \_\_\_\_\_

What are your recreational and fitness activities?

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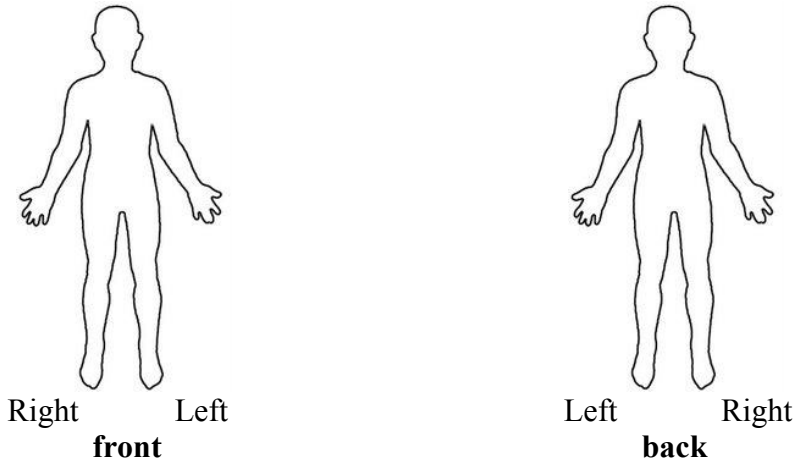
What are your goals for therapy?

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Pain Assessment:

Do you have pain? Y N  
If yes, draw your pain on the body chart below.



Rate your pain intensity on the line below  
0 = no pain 10= worst pain possible

0 \_\_\_\_\_ 10

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_