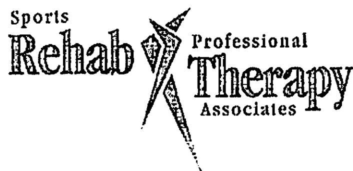

WOMEN'S HEALTH INTAKE FORM

Please answer the following questions to the best of your ability. I understand the paperwork is time-consuming, but the more thoroughly you complete this paperwork, the quicker I can determine your problem and begin helping you.

Name: ________________________________ **Date of Birth:** ___/___/_____

Eval Date: ___/___/_____

What is your primary problem or reason for seeking physical therapy?
When/how did your problem first begin? (describe and specify date if possible)
Previous treatments:
Medications:
Allergies: Latex   Tape/adhesives   Lotions   Lubricants   Other:

Personal Medical History - please check all that apply

Diabetes		Numbness/Tingling/Neuropathy		Dizziness/Fainting	
Stroke		Kidney Disease		Unexplained Fatigue	
Heart Attack		Headaches		Hepatitis	
High Cholesterol		Head Injury		Sexually Transmitted Disease	
High Blood Pressure		Fracture		HIV/AIDS	
Heart Disease/Failure		Vision Problems		Pelvic Inflammatory Disease	
COPD/Bronchitis		Hearing Problems		Endometriosis	
Asthma		Cancer (type if known)		Childhood Bladder Problems	
Seizures		Rheumatoid Arthritis		Recurrent Urinary Tract Infections	
Arthritis		Anxiety		Kidney Stones/Infections	
Acid Reflux		Depression		Blood in Urine	
Osteoporosis		Smoking History		Irritable Bowel Syndrome	
Thyroid Disease		Leg Swelling		Diverticulitis	
Clotting Disorder		Low Back Pain		Night Sweats	
Liver Problems		Buttock/Tailbone Pain		Weight Loss	
Anemia		Fibromyalgia		Abdominal Pain	

Other - please explain: ____

SURGICAL HISTORY

SURGERY	YEAR	SURGERY	YEAR

PAIN- Do you have pain? ☐ Yes ☐ No

If pain is present, rate your pain on a 1-10 scale, 10 being the worst: 1 2 3 4 5 6 7 8 9 10

Where is your pain located? Back Leg Groin Abdominals Buttocks Pelvic Region Vagina Anus

Other: ______________________________

Do you have pain with: Tampon Use Pelvic exams Sex/Penetration Other: ______________

Describe the nature of the pain (i.e., stabbing, burning, aching, numb) ______________

What relieves your symptoms? ______________________________

OB/GYN HISTORY- Number of pregnancies: Vaginal ________ Cesarean ________ Birth Weight of largest child ________

Did you push more than 2 hours?	☐ Yes ☐ No	Have you had an episiotomy?	☐ Yes ☐ No
Did you have significant tearing?	☐ Yes ☐ No	Did you have an assisted delivery (forceps/vacuum)?	☐ Yes ☐ No
Did you have any trouble healing after delivery?	☐ Yes ☐ No	Did you have a tailbone injury?	☐ Yes ☐ No

Describe any special pregnancy problems: ______________________________

Are you currently pregnant? ☐ Yes ☐ No Are you on birth control? ☐ Yes ☐ No Date of last PAP smear/internal exam: ________

If you are comfortable answering-- Have you ever been sexually abused? ☐ Yes ☐ No	Have you ever had a sexually transmitted disease? ☐ Yes ☐ No

Do you experience the following: Vaginal Dryness Chronic yeast infections Chronic vaginal discharge

Do you have regular menstrual cycles? ☐ Yes ☐ No Have you reached menopause? ☐ Yes ☐ No If so, when? ________

Menstrual cycle/menopause symptoms: ______________________________

____

Do you have feelings of organ "falling out" / prolapse or pelvic heaviness/pressure? ☐ Yes ☐ No

When/what activities increase this feeling? ______________________________

BLADDER HEALTH HISTORY- On average, how often do you urinate? Times/day: ________ Times/night: ________

The usual amount of urine passed is: Small Medium Large

When you have a normal urge to urinate, how long can you wait before you have to go to the toilet?

Minutes: ________ Hours: ________ Not at all ________

Do you have leaks? ☐ Yes ☐ No Times per day: _____ Times per week: _____ Times per month: _____ With exertion: _____

On average, how much urine do you leak? Just a few drops _____ Wets underwear _____ Wets outerwear _____ Wets the floor _____

What form of protection do you wear? None _____ Minimal protection: (tissue paper/paper towel/pantishields) _____

Moderate protection (absorbent product, maxipad) ______ Maximum protection (specialty product/diaper) _____ Other: ________

On average, how many pad/protection changes are required in 24 hours? # of pads ________

Do you have leaks with --please rate 0=not at all, 1=rarely, 2=sometimes, 3=frequently:(check all that apply):

Coughing	0 1 2 3	Sneezing	0 1 2 3	Laughing	0 1 2 3
Lifting Objects	0 1 2 3	Exercise	0 1 2 3	Jumping	0 1 2 3
Dancing	0 1 2 3	Sleeping at night	0 1 2 3	Hearing running water	0 1 2 3

Sitting	0 1 2 3	Standing	0 1 2 3	Walking	0 1 2 3
Bending	0 1 2 3	Changing position (i.e., sit to stand)	0 1 2 3	Putting a key in the door	0 1 2 3
With Nervousness/anxiety	0 1 2 3	Constant leakage	0 1 2 3	Having sex	0 1 2 3

Other: ____

Do you have - please rate 0=not at all, 1=rarely, 2=sometimes, 3=frequently:

A strong urge to urinate	0 1 2 3	Dribbling after urination	0 1 2 3
Trouble emptying your bladder	0 1 2 3	An inability to feel yourself leaking	0 1 2 3
Difficulty starting or stopping your urine stream	0 1 2 3	A need to strain to urinate	0 1 2 3
Urination more than 8 times per day	0 1 2 3	Painful urination	0 1 2 3

Have you had any urologic testing? ☐ Yes ☐ No If yes, please list results: ______________________

How many glasses of water do you drink per day? ________ What beverage do you drink most? ______________________

GASTROINTESTINAL HEALTH HISTORY- On average, how often do you move your bowels (per day/per week)? ______________

What is your most usual stool consistency? Liquid Soft Firm Pellets Other: ______________________

When you have a normal urge to move your bowels, how long can you wait before you have to go to the toilet?

Minutes: __________ Hours: ____________ Not at all ____________

When having a bowel movement, how long do you typically sit on the toilet? ______________________

Do you - please rate 0=not at all, 1=rarely, 2=sometimes, 3=frequently:

Have pain with bowel movements	0 1 2 3	Take laxatives/enemas regularly	0 1 2 3	Strain to move your bowels	0 1 2 3
Leak/stain	0 1 2 3	Have constipation	0 1 2 3	Have strong urges to move your bowels	0 1 2 3
Have frequent diarrhea	0 1 2 3	Have difficulty holding back gas	0 1 2 3	Have difficulty feeling bowels/urges/fullness	0 1 2 3
Have recent appetite changes	0 1 2 3	Have frequent nausea/mobiting	0 1 2 3	Have stool with unusual color/odor	0 1 2 3
Have gas/bloating	0 1 2 3	Have heartburn or reflux	0 1 2 3	Have blood or mucus in your stool	0 1 2 3
Have hemorrhoids	0 1 2 3				

If you have leaks, how much stool do you lose? Stool staining ______ Small amount in underwear _____ Complete emptying ______

How frequently do you leak stool/gas? ______________________

What activities/events cause you to leak stool? ______________________

Have you had a colonoscopy? ☐ Yes ☐ No When? ______________________

Do you include fiber in your diet? ☐ Yes ☐ No

FUNCTIONAL LIMITATIONS-

On a scale of 0 - 100 (0=no limitations in my daily activities because of my problem, 100=I am completely disabled due to my problem), what would you rate your functional limitations as? ______________________

Pelvic Floor Impact Questionnaire—short form 7 (PFIQ-7)

Name______________________ **DATE**______________

DOB______________________

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question, check the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months.** Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions in the following usually affect your	***Bladder or urine***	***Bowel or rectum***	***Vagina or pelvis***
1. Ability to do household chores (cooking, laundry housecleaning)?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
3. Entertainment activities such as going to a movie or concert?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
5. Participating in social activities outside your home?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
6. Emotional health (nervousness, depression, etc)?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
7. Feeling frustrated?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit

Total x 100 x 100 x 100
Scoring the PFIQ-7: =
All of the items use the following response scale:
0, Not at all; 1, somewhat; 2, moderately; 3, quite a bit **PFIQ-7 Score Scales:**
Urinary Impact Questionnaire (UIQ-7): 7 items under column heading "Bladder or urine"
Colorectal-Anal Impact questionnaire (CRAIQ-7): 7 items under column heading "Bowel / rectum"
Pelvic Organ Prolapse Impact Questionnaire (POPIQ-7): Items under column "Pelvis / Vagina"
Scale Scores: Obtain the mean value for all of the answered items within the corresponding scale (possible value 0 – 3) and then multiply by (100/3) to obtain the scale score (range 0-100).
Missing items are dealt with by using the mean from answered items only.
PFIQ-7 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0-300).