**Name: Date:**

**What pronouns do you prefer that we use when talking about you? (check all that apply)**

☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your current gender identity? (Check ALL that apply)**

☐ Male ☐ Female

☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer

☐ Additional category (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Decline to answer

**What sex were you assigned at birth? (Check one)**

☐Male ☐ Female ☐ Other ☐ Decline to answer

**Check reason/s seeking therapy services:**

\_\_\_\_Constipation \_\_\_\_Dysfunction \_\_\_\_Frequency \_\_\_\_Leakage

\_\_\_\_Lessen Pain \_\_\_\_Improve Bladder Control

\_\_\_\_Pelvic Pain \_\_\_\_Prolapse \_\_\_\_Urgency \_\_\_\_Sexual Dysfunction

\_\_\_\_Other (Describe):

**Check OTHER current symptoms you are experiencing:**

\_\_\_\_Fatigue Weakness \_\_\_\_ Fever/Chills/Sweats \_\_\_\_ Interrupted Sleep

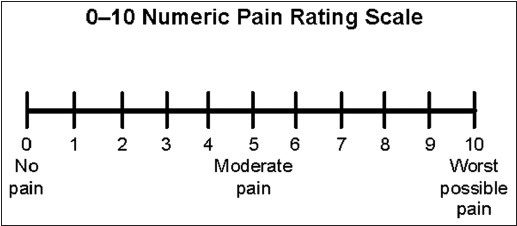
\_\_\_\_ Weight Loss/Gain \_\_\_\_Night Pain/Sweats \_\_\_\_ Numbness/Tingling

\_\_\_\_ Nausea/Vomiting \_\_\_\_ OTHER (Describe):

**Please explain the problem more and tell when you first noticed the problem.**

**How has it changed in the past year?** \_\_\_\_\_Same \_\_\_\_\_Worse \_\_\_\_\_Better

**Check Your Pain Level:**



**Describe Pain:**

**\_\_\_\_\_**None\_\_\_\_\_Constant Burning \_\_\_\_\_Intermittent Ache \_\_\_\_\_Other

Describe:

**Please list SPECIALISTs you have seen (Neurologist, Psychologist/Psychiatrist, Urologist, etc.**)

DATE LOCATION SPECIALIST RESULTS

**Please list Diagnostic TESTS (i.e. urinalysis performed, treatments given, & exercises done for current problem):**

DATE LOCATION Diagnostic Tests/Treatments/Exercises RESULTS

**Check the following conditions you are experiencing or have experienced:**

\_\_\_Abuse

\_\_\_Acid Reflux/Belching

\_\_\_Alcohol/Drug Addiction

\_\_\_Ankle Swelling

\_\_\_Anorexia/Bulimia

\_\_\_Childhood Bladder Problems

\_\_\_Chronic Fatigue Syndrome

\_\_\_Endometriosis

\_\_\_Fibroids

\_\_\_Fibromyalgia

\_\_\_Head Injury

\_\_\_Headaches

\_\_\_Hearing/Vision Loss

\_\_\_Irritable Bowel Syndrome

\_\_\_Joint Replacement

\_\_\_Latex Sensitivity

\_\_\_Low Back Pain

\_\_\_Osteoporosis

\_\_\_Pelvic Pain

\_\_\_Physical/Sexual Abuse

\_\_\_Polycystic Ovarian Syndrome (PCOS)

\_\_\_Reynaud’s Disease

\_\_\_Sacroiliac/Tailbone pain

\_\_\_Sexually Transmitted Disease

\_\_\_Sjogren’s Syndrome

\_\_\_Smoking History

\_\_\_Sports Injury

\_\_\_Stress Fracture

\_\_\_TMJ Neck Pain

\_\_\_Other

**Please list any hospitalizations, injuries, and other chronic or severe illness you have experienced:**

DATE HOSPITALIZATIONS/INJURIES/SURGERIES/OTHER REASON

**Please list all PRESCRIPTION (Rx) and OVER THE COUNTER (OTC) medications that you are currently taking (Include all injectable, oral, rectal, and topical MEDICATIONS**):

**Please complete ONLY the sections that are relevant:**

**Are you PREGNANT? \_\_\_\_** Yes \_\_\_\_ No **Are you trying to get PREGNANT**? \_\_\_\_ Yes \_\_\_\_ No

Number of Pregnancies? ­\_\_\_­\_\_ Number of Live Births? \_\_\_\_\_ Number of Vaginal Childbirths? \_\_\_\_\_\_

Number of Episiotomies? ­\_\_\_\_\_ Number of C-Sections? \_\_\_\_\_ Number of Difficult Childbirths? \_\_\_\_\_\_

Year(s) of pregnancies Weight of Largest Delivery:

\_\_\_\_Painful Periods Menopause - Age? \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Painful Penetration Pain with tampon insertion

\_\_\_\_Other (Describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Pelvic/Genital Pain (Location?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Erectile Dysfunction \_\_\_\_\_Painful Ejaculation

\_\_\_\_Prostate Disorders \_\_\_\_\_Shy Bladder \_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check current BLADDER symptoms you are experiencing:**

\_\_\_\_\_Blood in urine

\_\_\_\_\_Urine leakage

\_\_\_\_\_Difficulty emptying

\_\_\_\_\_Difficulty starting

\_\_\_\_\_Difficulty stopping

\_\_\_\_\_Dribbling

\_\_\_\_\_Difficulty feeling

\_\_\_\_\_Painful urination

\_\_\_\_\_Recurrent infections

\_\_\_\_\_Strain to empty

\_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_

**Check or complete the following BLADDER questions:**

Frequency of urination: \_\_\_\_\_Times per day \_\_\_\_\_Times during the night

Length of time urine held after a normal urge to urinate: \_\_\_\_\_Not at all \_\_\_\_\_# of minutes

The usual amount of urine passed: \_\_\_\_\_Small \_\_\_\_\_Medium \_\_\_\_\_Large

Frequency of **BLADDER** leakage: \_\_\_\_\_No leakage \_\_\_\_\_Times/day \_\_\_\_\_Times/week

Activity when leakage noted: \_\_\_\_With cough/sneeze \_\_\_\_\_With exercise \_\_\_\_\_With strong urge

\_\_\_\_\_Running water \_\_\_\_\_Hands in water

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check current BOWEL MOVEMENT (BM) symptoms you are experiencing:**

\_\_\_\_\_Blood in stool/feces

\_\_\_\_\_Constipation/straining

\_\_\_\_\_Diff. controlling urge

\_\_\_\_\_Diff. emptying

\_\_\_\_\_Diff. feeling fullness

\_\_\_\_\_Diff. holding gas/BM

\_\_\_\_\_Need for laxatives

\_\_\_\_\_Support required to void

\_\_\_\_\_ Painful BM

\_\_\_\_\_ Seepage/loss of BM

\_\_\_\_\_ Staining of underwear

\_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check or complete the following BOWL MOVEMENT (BM) questions:**

Frequency of BM’s: \_\_\_\_\_Times per day \_\_\_\_\_Times during the night

Length of time BM held after a normal urge to defecate: \_\_\_\_\_Not at all \_\_\_\_\_# of minutes \_\_\_\_\_ # of hours

The usual amount of BM passed: \_\_\_\_Small \_\_\_\_\_Medium \_\_\_\_\_Large

Frequency of **BOWEL** leakage: \_\_\_\_No leakage \_\_\_\_Times/day \_\_\_\_Times/week \_\_\_Times/month

Activity when leakage noted: \_\_\_\_With cough/sneeze \_\_\_\_\_­With exercise \_\_\_\_\_With strong urge to urinate

Triggers/encourage BM’s: \_\_\_\_Yes \_\_­­\_\_\_No \_\_\_\_\_Other (Explain)

**Rate** a feeling of **organ “falling out”/prolapsed or pelvic heaviness/pressure**:

\_\_\_\_None present \_\_\_\_Times per month \_\_\_\_Related to activity \_\_\_\_Related to menstrual period, \_\_\_\_When standing (for \_\_\_\_minutes, \_\_\_\_hours)

\_\_\_\_With exertion \_\_\_\_Other (Describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check and Complete all activities/events that cause or aggravate your symptoms**:

\_\_\_\_Changing positions (i.e., sit to stand) \_\_\_\_Light activity/housework

\_\_\_\_No activity affects \_\_\_\_Sitting greater than \_\_\_minutes

\_\_\_\_Standing greater than \_\_\_minutes \_\_\_\_Sexual activity:

\_\_\_\_With cold weather: \_\_\_\_Vigorous activity/exercise (run/weight lift/jump)

\_\_\_\_Walking greater than \_\_\_minutes \_\_\_\_With cough/sneeze/straining

\_\_\_\_With laughing/yelling; \_\_\_\_With lifting/bending

\_\_\_\_With triggers (i.e. key in door) \_\_\_\_With nervousness/anxiety

\_\_\_\_Other (Describe):

**Complete:** Ways you use to relieve your symptoms

**Mental Health:** 1) \_\_\_Happy; 2) \_\_\_Low stress; 3) \_\_\_Mod stress: 4) \_\_\_High stress; 5) \_\_\_Other

**Fluid Intake:**

Water drinking: \_\_\_\_None \_\_\_\_1-3 glasses per day \_\_\_\_4-6 glasses per day \_\_\_\_7 or more glasses per day

Fruit juice: \_\_\_\_None \_\_\_\_1-3 glasses per day \_\_\_\_4-6 glasses per day \_\_\_\_7 or more glasses per day

Caffeinated: \_\_\_\_None \_\_\_\_1-3 glasses per day \_\_\_\_4-6 glasses per day \_\_\_\_7 or more glasses per day

Soda: ­\_\_\_\_None \_\_\_\_1-3 glasses per day \_\_\_\_4-6 glasses per day \_\_\_\_7 or more glasses per day

Other: \_\_\_\_None \_\_\_\_1-3 glasses per day \_\_\_\_4-6 glasses per day \_\_\_\_7 or more glasses per day

What amount of the above fluid intake occurs between 8 am and 6 pm? \_\_\_All \_\_\_1/2 \_\_\_3/4 \_\_\_None

What fluid and how much is taken at bedtime?

**Check the way you best learn:**

\_\_\_\_Listening (discussion, lecture, CDs); \_\_\_\_Seeing (reading, DVD’s, displays, slides);

\_\_\_\_Doing (demonstration, practicing skill); \_\_\_\_Don’t know