VAUGHAN PHYSIOTHERAPY CLINIC

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Scan for your patient portal: book, forms and receipts

Pelvic Health Intake

Get better today.

Your visit is in a private room. An internal exam is only done with your consent, and you can skip any question you prefer to talk about in person.

Patient name *		Date of birth *	Y Y Y Y - M M - D D

A. Reason for your visit

Main concern	☐ Leaking with cough or sneeze ☐ Urgency ☐ Frequency ☐ Bowel control ☐ Constipation ☐ Pelvic pain ☐ Pain with intercourse ☐ Heaviness / prolapse ☐ Pregnancy ☐ Postpartum ☐ Prostate surgery ☐ Diastasis ☐ Other _____		
How long has this been going on?		**Your goal for therapy**	

B. Bladder and bowel

Toilet trips in the day		**Times up at night**	
Pads per day		**Bowel movements per week**	
Fluids per day (cups)		**Coffee / tea / alcohol per day**	
Leaking happens with	☐ Cough / sneeze ☐ Exercise ☐ Lifting ☐ On the way to the toilet ☐ Without warning ☐ No leaking ☐ Other _____		

C. Pregnancy and history

Number of births		**Type of birth(s)**	☐ Vaginal ☐ Caesarean ☐ Both ☐ Not applicable
Due date or last delivery	Y Y Y Y - M M - D D	**Menopause**	☐ Yes ☐ No ☐ Not applicable
Past history	☐ Tearing or episiotomy ☐ Forceps / vacuum ☐ Pelvic surgery ☐ Hysterectomy ☐ Prostatectomy ☐ Endometriosis ☐ Other _____		

Pelvic safety screen: please answer every question

Blood in urine or stool?	◯ Yes ◯ No	**Burning with urination or fever?**	◯ Yes ◯ No
Unusual or post-menopausal bleeding?	◯ Yes ◯ No	**New loss of bladder or bowel control with numbness?**	◯ Yes ◯ No
Pregnant with bleeding, fluid or severe pain?	◯ Yes ◯ No	**Unexplained weight loss or new lump?**	◯ Yes ◯ No

D. Your comfort

Internal exam	☐ Open to it ☐ Not today ☐ Want to discuss first	**Preferred therapist**	☐ No preference ☐ Female therapist
Notes for your clinician			

Signature *		Date *	Y Y Y Y - M M - D D