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Pelvic Therapy Subjective

Please answer every question

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SUMMIT ORTHOPEDICS

Marking Instructions ⬬

Please use black ink. Fill in the complete oval as shown.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

AGE

REASON FOR VISIT

- ◯ initial evaluation
- ◯ consultation
- ◯ worsening symptoms
- ◯ follow-up / routine clinic

other: _____

PAST EVALUATION

- ◯ **NONE**
- ◯ pregnancy test
- ◯ STD testing
- ◯ CA 125
- ◯ FSH
- ◯ Estradiol
- ◯ gynecology evaluation
- ◯ diagnostic laparoscopy
- ◯ laparoscopic pain mapping
- ◯ neurology evaluation
- ◯ general surgery evaluation
- ◯ pelvic ultrasound
- ◯ pelvic MRI
- ◯ pelvic CT
- ◯ barium enema
- ◯ colonoscopy
- ◯ urology evaluation
- ◯ GI evaluation
- ◯ IVP
- **other:** _____

PAST TREATMENT

- ◯ **NONE**
- ◯ NSAIDs
- ◯ physical therapy
- ◯ anticonvulsants
- ◯ antidepressants
- ◯ bilateral oophorectomy
- ◯ continuous oral contraceptives
- ◯ continuous progrestin therapy
- ◯ uterine artery embolization
- ◯ androgen hormone inhibitors
- ◯ non-opioid analgesics
- ◯ opioid analgesics
- ◯ GNRH analog therapy
- ◯ mental health care
- ◯ surgical adhesiolysis
- ◯ acupuncture
- ◯ hysterectomy
- ◯ TENS unit
- **other:** _____

Was the treatment effective for alleviating pain? ◯ yes ◯ no

SYMPTOMS

Are you currently experiencing symptoms? ◯ yes ◯ no

- ◯ pelvic pain
- ◯ vulvar pain
- ◯ diarrhea
- ◯ coccyx pain
- ◯ urinary incontinence
- ◯ gas or fecal incontinence
- ◯ numb genital/groin region
- ◯ vulvovaginal pain
- ◯ painful intercourse
- ◯ painful urination
- ◯ painful menstruation
- ◯ painful bowel movements
- ◯ constipation
- ◯ cramping
- ◯ rectal pain
- ◯ abdominal pain

PAIN

Are you currently experiencing pain? ◯ yes ◯ no

0 = no pain **10 = intolerable**

How much pain are you experiencing now? ☺ ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 ☹

What is your pain level at its worst? ☺ ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 ☹

What is your pain level at its least? ☺ ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 ☹

PAIN LOCATION

- ◯ anterior pelvis
- ◯ deep pelvis
- ◯ diffuse pelvis
- ◯ right pelvis
- ◯ left pelvis
- ◯ right to left
- ◯ left to right
- **other:** _____

EXACERBATING FACTORS

- ◯ **NONE**
- ◯ leg extension
- ◯ leg rotation
- ◯ leg flexion
- ◯ sitting
- ◯ standing
- ◯ strenuous activity
- ◯ intercourse
- ◯ menses
- ◯ constipation
- **other:** _____

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RELIEVING FACTORS

- ◯ **NONE**
- ◯ rest
- ◯ heat
- ◯ NSAIDs
- ◯ non-opioid analgesics
- ◯ opioid analgesics
- ◯ relaxation therapy

other: _____ _____

ASSOCIATED SYMPTOMS

- ◯ **NONE**
- ◯ depression
- ◯ anxiety
- ◯ sleep disturbance
- ◯ weight loss
- ◯ anorexia
- ◯ nausea
- ◯ vomiting
- ◯ bowel changes
- ◯ headache

other: _____

INCONTINENCE

- ◯ **NONE**
- ◯ bowel
- ◯ bladder
- ◯ gas

Protection used:

- ◯ **NONE**
- ◯ bladder control pad
- ◯ pantishields
- ◯ undergarment/diaper
- ◯ mini pad
- ◯ maxi pads

Severity:

- ◯ few drops
- ◯ no leakage
- ◯ wet underwear
- ◯ wet outerwear

Position or activity with leakage:

- ◯ lying down
- ◯ changing positions
- ◯ sexual activity
- ◯ standing
- ◯ strong urge
- ◯ sitting

Urination delay:

- ◯ not at all
- ◯ indefinitely
- ◯ less than 10 minutes
- ◯ 1-2 minutes
- ◯ 15 minutes
- ◯ 30 minutes
- ◯ 1 or more hours

Urine loss activity:

- ◯ no activity
- ◯ light activity
- ◯ moderate activity
- ◯ vigorous activity

type: _____

Prolapse (falling out feeling):

- ◯ never
- ◯ occasionally / with menses
- ◯ pressure with standing
- ◯ pressure with straining
- ◯ pressure end of day
- ◯ pressure all day

Frequency of urination:

Day:	◯ 0	◯ 1-4	◯ 5-8	◯ 9-12	◯ 13+
Night:	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4+

Fluid intake (8 oz of water or beverages per day):

non-caffeinated:	◯ 1-2	◯ 3-5	◯ 6-8	◯ 9+
caffeinated:	◯ 1-2	◯ 3-5	◯ 6-8	◯ 9+

Frequency of bowel movements:

- ◯ 1 time per day
- ◯ 2 times per day
- ◯ every other day
- ◯ weekly
- ◯ once every 4-7 days

After you start to urinate, can you completely stop the flow of urine?

- ◯ stop completely
- ◯ maintain a deflection
- ◯ partially deflect
- ◯ unable to deflect

Do you have trouble initiating a urine stream?

- ◯ never
- ◯ more than once per month
- ◯ more than once per week
- ◯ almost every day

How inconvenient is this for you?

- ◯ not at all
- ◯ slightly
- ◯ minorly
- ◯ moderately
- ◯ majorly

How much confidence do you have?

- ◯ complete
- ◯ moderate
- ◯ little
- ◯ none

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FUNCTIONAL LIMITATIONS

- general activity
- mood
- walking ability
- work
- pain with pelvic exam
- back/leg/groin/abdominal pain
- pain with tampon use
- hobbies
- pain with intercourse
- housework
- social relationships
- sleep
- enjoyment of life
- ADLs

other: _____

CURRENT TREATMENT

- **NONE**
- NSAIDs
- physical therapy
- anticonvulsants
- androgen hormone inhibitors
- continuous oral contraceptives
- continuous progrestin therapy
- antidepressants
- non-opioid analgesics
- opioid analgesics
- GNRH analog therapy
- TENS unit
- mental health care
- acupuncture

other: _____

MEDICAL HISTORY

- **NONE**
- uterine leiomymata
- autoimmune disease
- cervicitis
- prostate cancer
- proctitis
- Crohn's disease
- vaginitis
- ovarian cysts
- irritable bowel syndrome
- sexual abuse or trauma
- trouble healing after delivery
- interstitial cystitis
- hemorrhoids
- Hirschsprung's disease
- urolithiasis
- fissures/fistulas
- depression
- pelvic cancer
- pelvic adhesions

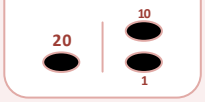
other: _____ _____

	0	1	2	3	4	5	6	7	8	9	10+
Total number of pregnancies	○	○	○	○	○	○	○	○	○	○	○
Number of vaginal deliveries	○	○	○	○	○	○	○	○	○	○	○
Number of episiotomies	○	○	○	○	○	○	○	○	○	○	○
Number of cesarean deliveries	○	○	○	○	○	○	○	○	○	○	○

What was the birth weight of your largest baby?

EXAMPLE

The year 2011 would look like this:



Pounds	○ 10	○ 20	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9
Ounces		○ 10	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9

Date of last pap smear:

Month	○ JAN	○ FEB	○ MAR	○ APR	○ MAY	○ JUN	○ JUL	○ AUG	○ SEP	○ OCT	○ NOV	○ DEC

Year	20 ○	○ 10	○ 20	○ 30	○ 40	○ 50	○ 60	○ 70	○ 80	○ 90
		○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9

SURGICAL HISTORY

- **NONE**
- hysterectomy
- prostatectomy
- cervical dilation procedures
- laparoscopic surgery
- colon/rectal surgery
- adhesiolysis
- tubal surgery
- pelvic floor surgery

other: _____ _____

HABITS

Do you use tobacco? ○ yes ○ no

Cigarettes per day: ○ none ○ <½ pack ○ ½ pack ○ 1 pack ○ 1 ½ packs ○ 2 packs ○ more than 2 packs

Do you use alcohol? ○ yes ○ no

Alcohol drinks per day: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 or more

Alcohol drinks per week: ○ 0-3 ○ 4-7 ○ 8-14 ○ 15-21 ○ 22 or more

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