Pelvic Health Intake Form - Males

Name: _____DOB (dd/mm/yyyy): _____

Occupation:_____

Age:_____

Hobbies/
Activities:_____

Do you presently, or have you ever suffered from any of the following (*check all that apply):*

- ☐ Cancer
- ☐ Ehler's Danlos
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Broken Bones/Fractures
- ☐ Arthritis
- ☐ Anxiety/Panic Attacks
- ☐ Depression
- ☐ Skin disease/sensitivity
- ☐ Irritable Bowel Syndrome
- ☐ Migraine or tension headaches
- ☐ Temporomandibular Pain (TMJ)
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Interstitial Cystitis/Bladder Pain Syndrome
- ☐ Chronic Prostatitis
- ☐ Restless Leg Syndrome
- ☐ Other:_____

Major Surgeries (and year):

_____

Were you referred by your doctor or other specialist? (If so, who?)

_____

Do you consent to your physiotherapist communicating her findings with your referring practitioner?…….
□Yes □No □N/A

Do you have extended health benefits for physiotherapy?
□Yes □No, I'm paying privately

What are your goals for Physiotherapy? (What would you like to improve?)

1._____

2._____

3._____

Pain History

Do you experience pain in your low back/hips/pelvis? …….
□Yes □No

What activities/things make this pain *worse*:

_____

What activities/things make this pain *better*:

_____

Do you experience pain in your rectum/genitals?

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□ Yes □ No

What activities/things make this pain *worse*:

_____

What activities/things make this pain *better*:

_____

How long have you had pain?

_____

Who have you seen about this pain?
□ Family Doctor □ Physiotherapist □ Chiropractor □ Massage □ Osteopath □ Urologist
□ Other: _____

Is your pain:
□ widespread □ localized to one area □ constant □ comes and goes □ predictable □ unpredictable

What do you think is causing your pain?:_____
_____
_____

Bladder/Bowel History

The following questions are about bladder leaks. If you do not experience bladder leaks, please select "Never".

In the past 4 weeks, how *often* do you leak urine?
□ Never □ About once per week or less often □ 2-3 times per week □ About once per day
□ Several times per day □ All the time

How *much* urine do you usually leak?
□ None □ A small amount □ A moderate amount □ A large amount

***When* does urine leak?**
□ Never (urine does not leak)
□ Leaks before you can get to the toilet
□ Leaks when you cough/sneeze
□ Leaks when you are asleep
□ Leaks when you are physically active/ exercising
□ Leaks during intercourse
□ Leaks when you are finished urinating and are dressed
□ Leaks for no obvious reason
□ Leaks all the time

Overall, how much does *leaking urine* interfere with your everyday life? Please select a number between 0 (not at all) and 10 (a great deal).

0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Do you ever have *difficulty emptying* your bladder completely? .....□ Yes □ No □ Sometimes
Do you have *pain* when you urinate?.....□ Yes □ No □ Sometimes
Do you need to *strain* to urinate?.....□ Yes □ No □ Sometimes
Do you get *blood* in your urine? .....□ Yes □ No □ Sometimes

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Do you have a history of Urinary Tract Infections (UTIs)? .....□Yes □No
Most recent:_____
How many times per day (on average) do you urinate?…… .□ < 5 □ 5-7 □ 7-10 □ > 10
Do you wake to urinate at night? .....# times per night
Does bladder leakage require you to wear pads? .....# pads per day
How many bowel movements (on average) do you have per week? ..... # times per week
Do you need to push or strain to have bowel movements? .....□Yes □No □Sometimes
Do you suffer from fecal incontinence (accidental leakage of stool)? ..... □Yes □No □Sometimes

Fluid Intake in 24 hours

cups of coffee: _____ # cups of tea: _____ # cups of water: _____ # cups of other fluids: _____

Sleep History

What time do you typically go to bed? _____ What time do you typically fall asleep? _____

What time do you get up in the morning? _____ Is your sleep interrupted? _____

Any additional comments about sleep?

_____

_____

_____

Physical Activity/Movement

Please describe any regular routines you have around physical activity (eg. walking, hiking, running, gym, group fitness)

_____

_____

_____

□ I don't have anything in my routine right now

Central Sensitization Questionnaire

Finally, I'm presenting you with a questionnaire that measures activity within the autonomic nervous system. Please select the best response that applies to you *over the past 4 weeks*.

1. I feel tired and unrefreshed when I wake from sleeping:…….□ Never □ Rarely □ Sometimes □ Often □ Always
2. My muscles feel stiff and achy:…….. □ Never □ Rarely □ Sometimes □ Often □ Always
3. I feel pain all over my body…….. □ Never □ Rarely □ Sometimes □ Often □ Always

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4. I have headaches…….. □ Never □ Rarely □ Sometimes □ Often □ Always
5. I do not sleep well…….. □ Never □ Rarely □ Sometimes □ Often □ Always
6. I have difficulty concentrating……. □ Never □ Rarely □ Sometimes □ Often □ Always
7. Stress makes my physical symptoms get worse…….. □ Never □ Rarely □ Sometimes □ Often □ Always
8. I have muscle tension in my neck and shoulders……. □ Never □ Rarely □ Sometimes □ Often □ Always
9. I have difficulty remembering things……□ Never □ Rarely □ Sometimes □ Often □ Always

Disclosure of trauma history – *optional*
It's important that you know that traumatic life events can affect our physiology. We are wired to respond to physiologically to stress and trauma as a survival response. Unfortunately for many people, chronic/unresolved trauma can negatively impact physical health for many years.
Because these experiences are so relevant to our physiology, and since our physiology lays the groundwork for neuromuscular function in the body, I ask all my patients about stressful or traumatic life events. This could include a history of sexual abuse, a traumatic childhood experience or any life event that has had a negative impact on you.
Please know that your comments are completely confidential and that you are welcome to share as much or as little detail
as you feel comfortable. Have you experienced trauma in your life?
□**Yes**, I have a history of trauma □**No**, I do not have a history of trauma □ Prefer not to disclose
Comments:

_____

_____

_____

_____

Is there anything else you would like to say? Other concerns or information that may help your therapist guide your treatment?

_____

_____

_____

_____

Please turn page over to review consent form.

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Consent

You are meeting with a Pelvic Health Physiotherapist because your symptoms suggest that there may be dysfunction of
the deep core muscles inside your abdomen and pelvis, including the pelvic floor muscles. There may be weakness, excessive tension, issues with motor control/coordination or other issues contributing to your symptoms. While my training enables me to perform internal assessments of the pelvic floor muscles (via rectal exam on men; vaginal exam on women), I do **not** often find this is necessary to do at every consultation with my male clients.

At your assessment, you can expect a thorough discussion about your health history, observation of your posture and general movement, and some *external* hands-on techniques on your ribcage, your pelvis/hips, abdomen and back.

If over the course of our time together I suspect that there is true dysfunction of the pelvic floor muscles, and *if* I feel that you would benefit from an internal assessment, I may make that recommendation at that time. (This is more likely if you have had prostate surgery, radiation therapy etc. and there is suspected injury of the pelvic floor muscles.) *Internal assessment is never mandatory and would only be presented as an option, if indicated under these circumstances.*

☐ I consent to engaging in subjective health history-taking, posture and movement analysis and *external* hands-on techniques for the purposes of identifying and addressing neuromuscular dysfunction of my trunk and pelvis.

Client Signature: _____

Date:_____

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