CONFIDENTIAL MEDICAL SCREENING QUESTIONNAIRE

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):*

□ Heart problems
□ High Blood Pressure
□ High Cholesterol
□ Stroke
□ Cancer
□ Diabetes
□ Lung problems
□ Osteoporosis
□ Broken Bones/Fractures
□ Arthritis
□ Kidney Problems
□ Repeated infections
□ Thyroid problems
□ Skin disease/sensitivity
□ Anxiety/Depression
□ Asthma
□ Epilepsy/Seizures
□ Hepatitis
□ HIV/AIDS
□ Pacemaker

Major Surgeries:

_____
_____
_____
_____
_____

Current medications:

_____
_____
_____
_____
_____

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

_____
_____
_____

_____

_____

Gynecological History (females only)

births:_____

Heaviest baby:_____lb____oz

Forceps/Vacuum for birth:_____

Length of (longest) pushing stage:____hours

Episiotomy: □Yes □No

Tearing: □Yes □No

C-Section: □Yes □No

Are you pregnant now? □Yes □No

Birth Control Method: _____

Last PAP Test:_____

Hormone Replacement Therapy: □Yes □No

Pain History

Do you have pain in your lower back/hips? □Yes □No

Do you have pain in your pelvis or genitals? □Yes □No

Are you sexually active? □Yes □No

Do you have pain with intercourse? □Yes □No

Do you experience "heaviness" in your pelvis? □Yes □No

Do you have any altered sensation?

□ Tingling □ Numbness

Where:_____

Do you have trouble sleeping? □Yes □No

□Falling asleep □Staying asleep □Night sweats

Bladder/Bowel History

Do you ever experience a sudden strong, uncomfortable urge to urinate? □Yes □No □Sometimes

Leakage of urine following strong, uncomfortable urge to urinate? □Yes □No □Sometimes

Leakage of urine with cough/sneeze/jump/other: □Yes □No □Sometimes

How many times per day (on average) do you urinate? _____# times per day

Do you wake to void at night? _____# times per night

Does your bladder leakage require you to wear pads? _____ # pads per day

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 have a history of Urinary Tract Infections (UTIs)?: □Yes □No

Do you get blood in your urine? □Yes □No

How many bowel movements (on average) do you have per week? _____ # bowel movements per week

Do you need to push or strain to have bowel movements? □Yes □No □Sometimes

Do you suffer from fecal (bowel) incontinence? □Yes □No □Sometimes

Fluid Intake in 24 hours

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

Many women have had unpleasant sexual experiences, including being touched against their will or physically abused. Approximately one in five women experience sexual abuse during childhood. Because these experiences
can affect pelvic health, I ask all of my patients about unwanted sexual experiences. 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 sexual abuse in your life?

□**Yes**, I have experienced sexual abuse □**No**, I have not experienced sexual abuse □ 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?

_____
_____
_____
_____
_____

Consent

Hopefully you have had an opportunity to review some materials about what to expect at your Pelvic Health Assessment. You are meeting with a Pelvic Health Physiotherapist because your symptoms suggest that there

may be dysfunction of the deep core muscles inside your pelvis. Proper assessment of these muscles requires in internal examination (via either vaginal or rectal palpation) and although it is strongly recommended that you have an internal exam, it is optional and dependent on your comfort. The benefits of internal palpation include the opportunity for your physiotherapist to objectively assess for pelvic floor muscle strength, tone, scar tissue and nerve function which helps your therapist develop the most appropriate treatment plan for you. The only risks of internal palpation are a temporary increase in current pelvic discomfort, or very minor bleeding. You are welcome to bring a person of your choosing into the room with you for your assessment/ treatment(s) if you wish, and you will also have the opportunity to ask any questions, voice concerns and to give/revoke your consent at anytime throughout your physiotherapy sessions.

By signing below I acknowledge that I have read and understand the above information and that I consent to receive treatment from a Pelvic Floor Physiotherapist with appropriate training to assess my pelvic floor through internal palpation.

Patient signature: _____ Date: _____