Date_____

PELVIC HEALTH

Patient name _____ DOB _____ Age _____

Address _____

City _____ State_____ Zip _____ Email _____

Phone _____ home/cell Alt. Phone _____ home/cell

Emergency contact _____relationship _____

Emergency contact phone number _____home/cell/ work

History of Present Injury

What brings you to pelvic floor physical therapy?_____

When did the most recent symptoms begin? _____

Have you had this problem before? if so, when did the symptoms start _____

How would you describe your complaints? _____

History of Pregnancy? Any miscarriages?_____

Any surgeries? (ie: prolapse repair, hysterectomy, cesarean delivery, tummy tuck, hip replacement)

_____

Goal for Physical Therapy _____

Please list all medication (prescription and/or over the counter) that you are taking, with dosages

_____

_____

_____

Medical history (please check all that apply)

HIV ___ Hepatitis ___ Stomach problems___ Skin disease ___ Diabetes ___ Cancer ___

Heart problems ___ CVA ___ Kidney ___ Liver ___ TIA ___ Lung problems ___

Circulatory problems ___ Urinary incontinence ___ Constipation ___ Head injury ___

Back/ neck injury ___

Please list any allergies that you have

_____