

Patient Name: _____



Date: _____

*** MEDICAL HISTORY – WOMEN’S HEALTH AND INCONTINENCE ***

Obstetrical / Gynecological History:

Number of pregnancies _____
Number of vaginal deliveries _____
Number of C-sections _____

Do you experience:

- Pain with intercourse
- Pain with pelvic exam
- Pain with tampon insertion
- Painful menses
- Menopause
- History of urine loss as a child
- Feeling of “falling out”
 - All day
 - Evening only

Bladder Symptoms:

Number of voids per day _____
Number of voids per night _____
Number of leaks per day _____
Number of leaks per night _____
Number of absorbent products used per day _____

Type of absorbent product:

- Thin
- Thick
- Pad
- Disposable Brief

Do you experience urine loss:

- With lifting
- With exercise
- On your way to the bathroom
- At the toilet or with removing clothes
- With intercourse
- Laugh, cough, or sneeze

Do you have:

- Urge to void when you hear running water
- Frequent UTI’s: Last date: _____
- To self-catheterize
- Burning with urination
- To strain to empty your bladder
- Dribbling after you empty your bladder
- The feel of urine in bladder post emptying

Bowel Symptoms:

Number of bowel movements per day _____
Do you include fiber in your diet? _____

- Dietary
- Supplemental

How much do you include? _____
In which meals do you take fiber:

- Breakfast
- Lunch
- Dinner
- Snacks

IF you have difficulty producing a bowel movement, Please answer the following:

How often do you successfully produce a bowel movement? _____
How long do you sit on the toilet with each attempt?

What helps you produce a bowel movement?

Do you use:

- Laxatives How often? _____
- Enemas How often? _____

Size of bowel movement:

- Small
- Medium
- Large

Consistency of bowel movement:

- Long and narrow
- Pellets
- Loose
- Soft
- Firm
- Hard

Do you experience:

- Pain with bowel movement
- Leakage or staining of stool
- Constipation
- Diarrhea



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GENERAL CONSENT FOR PELVIC FLOOR REHABILITATION EVALUATION AND TREATMENT

PATIENT NAME: _____ **DATE:** _____
Please Print

- ◆ I acknowledge that I have been referred to *TMS Physical Therapy* for evaluation and treatment of pelvic muscle, bone, or soft tissue problems.
- ◆ I understand that to evaluate my condition it may be essential, initially and periodically, to have my Physical Therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility, and muscle length. Such evaluation and treatment may include: observation, palpation, use of vaginal cones, vaginal or rectal sensors for biofeedback and/or electrical stimulation, exercise, soft tissue mobilization, education, instruction and neuromuscular techniques of the perineal and internal pelvic area.
- ◆ I understand that no guarantees can be provided regarding the success of therapy. I hereby request and consent to the evaluation and treatment to be provided by Physical Therapists, Physical Therapists Assistants, and Physical Therapy students of *TMS Physical Therapy*.

✓ ***Please check one of the following:***

_____ I would like to have a second person in the room with me during my internal assessment.

_____ I do not wish to have a second person in the room with me during my internal assessment.

Patient Signature

Signature of Parent / Guardian if appropriate