PELVICORE REHAB

A Total Body Approach To Healing.

Physical Therapy Department

Evaluation for male pelvic dysfunction

DEMOGRAPHIC AND INSURANCE INFORMATION (PHYSICAL THERAPY DEPARTMENT)

Today's Date: **First Appointment Date/time:**

Patients Legal Name	Maiden Name	Date of Birth Age
Patients Home Address	City/State/Zip Code	e-mail address
Social Securit. .:	Male or Female	Marital Status
Occupation	Employer	Employer's address
Home Phone	Work Phone	Cell Phone
Diagnosis	Referring Practitioner	Primary Care Physician
Medication Allergies	Food Allergies	Contrast/Other Allergies
Emergency Contact	Relationship	Phone #

For men, please indicate if you have had, or currently have the following:

Hernia	Y	N	P	Testicular mass	Y	N	P
Prostate enlargement	Y	N	P	Vasectomy	Y	N	P
Erectile dysfunction	Y	N	P	Premature ejaculation	Y	N	P
Injury to the penis	Y	N	P	Curvature of the penis	Y	N	P
Epididymitis	Y	N	P	Circumcision	Y	N	P
Injury to the scrotum	Y	N	P	Hydrocele or varicocele	Y	N	P
Pain with sexual function	Y	N	P	Painful ejaculation	Y	N	P

Have you had a hydrocele or varicocele repair? Y N

Did you have surgery for undescended testicles? Y N

Do you currently do self-testicular exams? Y N

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Have you recently had any of the following?

Y	N	Fever, chills	Y	N	Unexplained muscle weakness
Y	N	Dizziness, blurred vision	Y	N	Falls
Y	N	Unexplained weight change	Y	N	Fainting
Y	N	Night sweats not related to menopause	Y	N	Numbness or tingling
Y	N	Night pain unrelieved by movement	Y	N	Hallucinations
Y	N	Blood in urine or stool	Y	N	Fatigue, low energy
Y	N	Depression	Y	N	Suicidal thoughts

Do you have a pacemaker? Y N

Do you have any implanted devices (IUD, pumps, stimulators?)

Do you take blood thinning medication? Y N Do you take nitro for chest pain? Y N

Are you possibly pregnant? Y N

If you are possibly pregnant, or trying to get pregnant, alert your therapist and update about any change in condition.

When did you last have a physical exam?

What testing has been completed for your current complaints?

How would you describe your general health? Excellent Good Average Fair Poor

How would you describe your current stress level? High Medium Low

Do you currently have a counselor or psychologist? Yes No

How often do you exercise per week? 5-7 days 3-4 days 1-2 days None

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Have you ever had any of the following conditions? For Y = current condition, N = never had, P = significant issue in the past.

Cancer	Y	N	P	Stroke	Y	N	P	Emphysema or bronchitis	Y	N	P
Heart disease	Y	N	P	Epilepsy	Y	N	P	Asthma	Y	N	P
Ankle swelling	Y	N	P	Multiple sclerosis	Y	N	P	Allergies	Y	N	P
High or low blood pressure	Y	N	P	Head injury	Y	N	P	Latex sensitivity	Y	N	P
Low back pain	Y	N	P	Osteoporosis	Y	N	P	Thyroid issues	Y	N	P
Sacroiliac pain	Y	N	P	Chronic fatigue syndrome	Y	N	P	Headaches	Y	N	P
Tailbone pain	Y	N	P	Fibromyalgia	Y	N	P	Diabetes	Y	N	P
Alcohol abuse	Y	N	P	Arthritic conditions	Y	N	P	Kidney issues	Y	N	P
Drug abuse	Y	N	P		Y	N	P	Irritable bowel syndrome	Y	N	P
Depression	Y	N	P	Joint replacement	Y	N	P	Crohn's disease	Y	N	P
Disordered eating	Y	N	P	Fracture	Y	N	P	Diverticulitis or diverticulosis	Y	N	P
Smoking	Y	N	P	Stress fracture	Y	N	P	Sexually transmitted disease	Y	N	P
Vision issues	Y	N	P	TMJ pain	Y	N	P	Physical abuse	Y	N	P
Hearing issues	Y	N	P	Neck pain				Sexual abuse	Y	N	P
Swollen glands	Y	N	P	Post-traumatic stress disorder	Y	N	P	Pelvic pain	Y	N	P
Anemia	Y	N	P	Blood clots	Y	N	P	Hemorrhoids	Y	N	P
Anal fissure	Y	N	P	Anal fistula	Y	N	P	Bladder infections	Y	N	P

Please list **any** surgeries that you have had (spinal, abdominal, joint, etc.)

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For all, please answer the following:

Do you have a daily, pain-free bowel movement (BM)?	Y N
Sense of incomplete emptying after BM?	Y N
Pain with urge to have BM?	Y N
Pain with passing stool?	Y N
Bleeding with BM?	Y N
Do you strain to have a BM?	Y N
Do you spend more than 10 minutes on toilet?	Y N
Do you currently use laxatives?	Y N
Do you have difficulty holding back gas?	Y N
Do you experience bowel leakage?	Y N

If bowel leakage, how often? _____

If bowel leakage, what amount? (small or large?) _____

How long can you delay emptying with bowel urge? _____

How many times per week do you have a bowel movement? _____

How often during the day do you empty your bladder (void)? _____

How many times do you wake at night to empty your bladder? _____

How long can you wait to void when you get an urge? _____

Do you usually pass small, medium, or large amounts of urine? _____

Do you have difficulty starting the flow of urine?	Y N
Do you have an intermittent stream of urine?	Y N
Can you stop the flow of urine if you try?	Y N
Does your bladder feel empty after you void?	Y N
Do you strain, push or bear down to void?	Y N
Do you dribble after you void?	Y N
Do you have constant urine leakage?	Y N
Does it hurt to empty your bladder?	Y N
Do you empty your bladder to ease pain?	Y N
Can you tell when your bladder is full?	Y N
Do you experience leakage of urine?	Y N

If yes to leakage, how much urine? (small to large) _____

What kind of leakage protection do you use? (pad, diaper, etc.) _____

How many pads or diapers in 24 hours? _____

If yes to leakage, during what activities do you leak? (sleep, exercise, sex, walk, run, jump, etc.)

_____

If an average cup is 8 ounces or 1 cup, how many cups of water do you have per day? _____

How many caffeine beverages per day? _____ Soda? _____ Alcohol? _____