Still Water
PHYSICAL THERAPY

Name: _____ Date: _____

**Subjective Pelvic Floor Information**

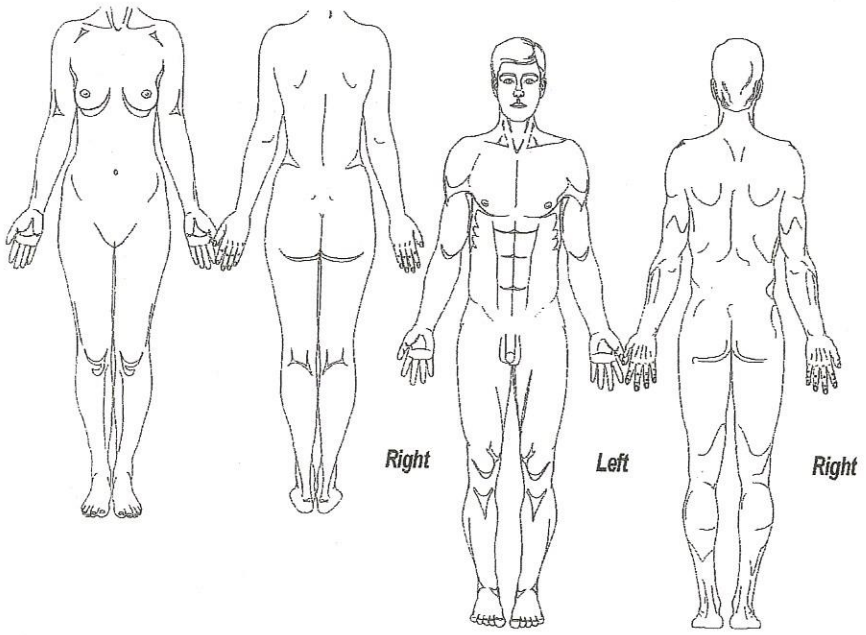
Please document as specifically as possible- please circle if applicable or write your respone

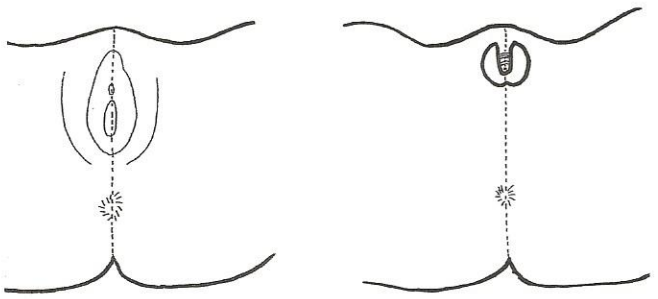
1. How do you think this happened: Fall, Repetitive Strain, Childbirth, Cycling, Prolonged Sitting, Surgery Other _____
2. Where are your symptoms? Please be specific
   _____
   _____
   _____
   _____
   _____
3. Is this Chronic or Recent
4. Pain Level: On a scale from 0(no pain) to 10(worst imaginable) what is the range of your pain Least _____/10 to worse _____/10. Is your pain on the surface or deep?
5. What is the frequency of you pain.

   0 (never) 1 2 3 4 5 6 7 8 9 10 (always)
6. What position makes the pain worse? Sitting (toilet or chair), standing, squatting, lying down, sidelying, walking, other? Do tight cloths produce pain or sensitivity
   _____
   _____
   _____
7. What position makes the pain better? Sitting (toilet or chair), standing, squatting, lying down, sidelying, walking, other?
   _____
   _____
   _____
8. Do you have any bladder issues – stress/urge incontinence, retention, dribbling, other?
   _____
   _____
   _____
9. Do you have any bowel issues – Constipation, diarrhea, leakage, pain with bowel movements and where do you feels this happen, sensation of foreign body in rectum or vagina, etc?
   _____
   _____
   _____

10. Do you have problems with sexual issue-pain, orgasm problems, erection problems, ejaculation problems?

11. Do you have any sensory changes and what are they? Groin, legs, buttocks



12. Do you have any pain elsewhere?

13. Are you on any medications? Please list names and dosages

14. Please tell me anything else that you need to let me know about.