PELVIC HEALTH INTAKE FORM
(Pediatric)

Patient Name: Date of Birth: / /	Date:
Parent/Guardian Name:_____ Relationship: _____	Date of last Menstrual Cycle: ____/____/____
Potty training "history":	Age of independent toileting:
Is there a history of urinary tract infections? ☐ No ☐ Yes Last infection:	Is there a history of sexual abuse or trauma? ☐ No ☐ Yes
Next visit with Provider:	

Pain:

Do you have pain with…	Yes:	No:
Bowel Movements		
Urination		
Menstruation/Management of Symptoms		
Back, Leg or Groin pain?		

Test Results:

Test	Yes	No	Results
Urodynamics			
Cystoscope			
Urine Test			
Bowel Test			

Patient Name: _____

Bladder Symptoms (check all that apply):

Do you lose urine when you…

Cough, Sneeze, Laugh: ☐ No ☐ Yes Lift/exercise/jump: ☐ No ☐ Yes

Hear running water: ☐ No ☐ Yes Have a strong urge to urinate: ☐ No ☐ Yes

On the way to the bathroom: ☐ No ☐ Yes

Do you wet the bed? ☐ No ☐ Yes

Do you have pain and/or burning with urination? ☐ No ☐ Yes

Do you have difficulty starting a stream of urine? ☐ No ☐ Yes

Do you ever need to strain to empty your bladder? ☐ No ☐ Yes

Do you ever feel your bladder did not fully empty? ☐ No ☐ Yes

Do you ever experience a "falling out" feeling in the genital region? ☐ No ☐ Yes

Do you experience pain with a full bladder? ☐ No ☐ Yes

Do you experience a strong urge for urination frequently? ☐ No ☐ Yes

Do you urinate more than 7x/day? ☐ No ☐ Yes

Bowel Symptoms (check all that apply):

Strain to have a bowel movement? ☐ No ☐ Yes

Include fiber in your diet? ☐ No ☐ Yes

Take laxatives/enema regularly? ☐ No ☐ Yes

Have pain with a bowel movement? ☐ No ☐ Yes

Leak or stain feces? ☐ No ☐ Yes

Have diarrhea often? ☐ No ☐ Yes

Leak gas by accident? ☐ No ☐ Yes

Have a very strong urge to move your bowels? ☐ No ☐ Yes

How often do you move your bowels? ___x/day or ___x/week

Most common stool consistency (please circle):

Loose Soft Firm Pellets Other: _____