

HEALTHY CORE

WELLNESS & REHAB, LTD.

Pelvic Floor Screening Form-Male

Directions: Please print this form and fill out the information as completely as possible. Please have the completed form available for your therapist to review with you at your appointment. The information you provide is strictly confidential and will be used to help us provide the most appropriate treatment for you. Thank you for your cooperation.

Personal Information

Name:	Age:	Date of Birth:
Signature:	Today's Date:	

Bladder Habits

1. How many times do you empty your bladder/urinate per day?	
2. How many times do you wake up to empty your bladder/urinate at night?	
3. Do you experience a sudden urgency to urinate? If yes, what causes it? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have difficulty starting your urine stream?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have a weak or slow urine stream?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you feel that you completely empty your bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had to self-catheterize to empty your bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you have blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Do you have pain or burning with urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do you ever have unintentional loss of urine (incontinence)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what causes it? (check all that apply) <input type="checkbox"/> Laughing <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing <input type="checkbox"/> Exercise <input type="checkbox"/> Urgency <input type="checkbox"/> Cold temperature <input type="checkbox"/> Running water <input type="checkbox"/> Lifting <input type="checkbox"/> Changing positions <input type="checkbox"/> Other: _____	
11. Do you wear protective pads? If yes, what type and how many per day? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

PH: 330-528-0034
 FAX: 330-528-3149
 1330 Corporate Drive, Suite 500, Hudson OH 44236
 E-MAIL: info@healthycorewellness.com
www.healthycorewellness.com

Pelvic Floor Screening Form (Page 2)

Bowel Habits

12. Have you ever had any unintentional loss of stool?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Do you have uncontrollable gas?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Do you have constipation or a history of straining to have a bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Do you take stool softeners or fiber supplements? If yes, what kind and how often? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Fluids

16. Approximately how much fluids (in ounces) do you drink each day?	_____ ounces
17. What types of fluids do you usually drink? <input type="checkbox"/> Water <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda (diet) <input type="checkbox"/> Soda (regular) <input type="checkbox"/> Other: _____	
18. Do you drink caffeine every day? If yes, what kind and approximately how much? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Pelvic Floor Exercises

19. Have you ever been instructed in performing pelvic floor exercises (Kegels)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Do you perform pelvic floor exercises? If yes, how often? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Sexuality

21. Do you experience pain with sexual activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Have you had anyone touch you without your consent, or had any traumatic sexual experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Thank you for your time in completing this information.