RESULTS PHYSIOTHERAPY

MALE INTAKE FORM

Please describe your pain/problem:_____

What do you think is causing your pain/problem?_____

Is there an event (or surgery) that you associate with the onset of your pain/problem? YES NO

If so, what? _____

How long have you had this pain/problem?_____

How much is your problem affecting your quality of life? Please rate 0-10:

0 1 2 3 4 5 6 7 8 9 10

No Effect Severe Impairment

My problem affects my quality of life in the following ways: (please circle)

Travel Social Sleep Job Self-care (dressing, bathing, etc.) Household activities/Yard work

Please rate your level of pain on this scale 0-10 (0 = no pain, 10 = severe pain)

0 1 2 3 4 5 6 7 8 9 10

No pain Severe Pain

URINARY PROBLEMS:

How many times per day do you void? Please circle: 8 or less 9-15 >16

Is your stream of urine weak and/or interrupted? YES NO

Do you experience pain before, during, or after urinating? YES NO

Does anything aggravate your urinary symptoms?_____

Does anything (positions, diet, etc) improve your urinary symptoms?_____

Do you have any difficulty starting your stream of urine (urinary hesitancy)? YES NO

Do you have any urinary leakage? YES NO

How often do you leak urine? 0 Never 1 1-4 times per month 2 2-4 times per week 3 Once per day 4 More than once per day: How many?_____	How much urine do you leak? 0 None 1 Few drops 2 Enough to wet underwear/pad 3 Enough to soak underwear/pad 4 Wets my outer clothes/runs down my leg/wets the floor
What type of pads do you use? 0 None 1 Thin pad 2 Maxi pad/thick pad 3 Heavy pads like Depends or diapers	How many pads do you use? 0 None 1 I only use pads during certain activities 2 1 pad per day 3 2-4 pads per day 4 More than 4 pads per day
How often do you get up at night to urinate? 0 0-1 time per night 1 1-2 times per night 2 3-4 times per night 3 5-6 times per night 4 More than 6 time per night	Activity that causes urine loss 0 No activity causes leakage 1 Light activity causes leakage 2 Moderate activity causes leakage 3 Vigorous activity causes leakage 4 Leakage with all physcial activity other_____

BOWEL PROBLEMS:

Do you have a history of constipation? YES NO

Do you have any fecal leakage? YES NO

If so, do you wear pads? How many per day?_____

If so, how much do you leak? A few drops Stain your underwear Stain your clothes

How often do you have a bowel movement? Per day?_____ Per week?_____

What is the consistency of your stool? Please see chart. _____

Do you experience pain before, during, or after a bowel movement? YES NO

Do you strain to have a bowel movement? YES NO

Do you have anal fissures or hemorrhoids? YES NO

Does anything make your bowel movements worse (activity, etc.)? _____

Does anything make your bowel movements better (position, diet, etc.)? _____

Are you currently taking anything (stool softeners, laxatives, etc.)? YES NO

What is our fluid intake per day (amount and type of fluid)?_____

Have you made any dietary changes? YES NO If so, what_____

SEXUAL FUNCTIONING:

Are you able to obtain an erection? YES NO

Are you able to ejaculate? YES NO

Do you experience any pain or urinary/bowel symptoms before, during, or after an ejaculation?

YES NO