WOMEN`S HEALTH PHYSIOTHERAPY FORM

GENERAL INFORMATION

Name: _____

Age: _____

Email: _____

Occupation: _____

Maternity leave since (date)	Retired since (date)

Physical activity and hobbies: _____

Frequency: _____

What are your main concerns and reasons for visit (please circle all that apply)

☐ Gap in tummy muscles (diastasis)	☐ Bladder problems/ leaking	☐ Bowel issues	☐ Pelvic girdle pain
☐ Prolaps	☐ Mood imbalance/ anxiety	☐ Pain on intercourse/ other sexual concerns	☐ Back pain
Any other concerns/reasons			

What are your main goals and/or expectations? _____

_____

_____

How long have you had the problem? _____

Has your problem changed over time? (better/worse/the same) _____

Please list up to three activities, movements or positions that bring on your pain/problem (e.g. Lifting, running, sitting)

1.	
2.	
3.	

OBSTETRIC HISTORY

Child	Age	Method of delivery	Weight of baby at birth	Weight gain during pregnancy (kg)	Were you physically active during pregnancy? (yes/no)
1.					
2.					
3.					

URINARY SYMPTOMS

Urinary frequency (going often) ☐	Pain on passing urine ☐	Reduced flow of urine ☐	UTIs (infections) ☐
Urinary urgency (rushing to go) ☐	Leaking on cough, exercise etc ☐	Problems emptying your bladder completely ☐	Assistance to empty your bladder ☐

BOWEL SYMPTOMS

Chronic constipation ☐	Involuntary leakage of solid stool ☐	Urgency (rushing to go) ☐
Chronic diarrhoea ☐	Involuntary leakage of watery stool ☐	Not feeling that you empty your bowel completely ☐
Pain on opening bowel ☐	Involuntary leakage of flatus (wind) ☐	Assistance to empty your bowel ☐

DIASTASIS

Noticeable gap between your tummy muscles ☐	Difficulty activating your tummy muscles ☐	Struggling to regain your core ☐

PELVIC FLOOR SYMPTOMS

Vaginal pressure/heaviness or a dragging sensation ☐	Pain/discomfort while inserting or wearing a tampon ☐	Pain during intercourse ☐
Sensation of tissue protrusion/lump/bulging in your vagina ☐	Previously diagnosed with a prolaps ☐	Pins and needles or numbness in your genital area ☐

GENERAL HEALTH

Please mark all that apply

Thyroid disease ☐	Heart problems ☐	Respiratory problems (asthma etc) ☐
Diabetes ☐	Bowel conditions (IBS, Colitis, etc) ☐	Connective tissue disorders (RA, lupus, etc) ☐
Anaemia ☐	High blood pressure ☐	Low blood pressure ☐
Endometriosis ☐	Back pain ☐	Hypermobility ☐
Menopause ☐	Fatigue ☐	Depression ☐
Other conditions/comorbidities		
Current medications	Smoking (how many per day?)	
Any gynaecological, urological or other surgeries in the back and abdomen area (year, type)		
Fractures/Traumas		

Physiotherapy treatment is voluntary and patient´s own responsibility. All the information will remain confidential and will not be shared with third parties.

_____ _____

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