INTAKE FORM - FEMALE

Name _____ Date_____

Date of Birth _____

1. Please respond to the following statements regarding your **PAIN** symptoms:
   - Nature (stabbing, burning, aching, etc.):
   - Location (please list all areas of pain):
   - Aggravating factors:
   - Alleviating factors:
   - Is the pain intermittent or constant:
   - When symptoms began:
   - What do you think caused the symptoms?

2. Please answer the following questions regarding your **URINARY** symptoms:

   - Do you have difficulty initiating your stream (urinary hesitancy)?
   - Is the stream weak and/or interrupted?
   - How many times a day do you void?
   - How many times do you wake up at night to void?
   - Do you experience pain before, during, or after voiding?
   - Do any behaviors aggravate your urinary symptoms?
   - Does anything (positions, diet, etc.) improve your urinary symptoms?

3. Please answer the following questions regarding your **BOWEL** habits:

   - Do you have a history of constipation?
   - How often do you have a bowel movement?
   - Do you experience pain before, during or after a bowel movement?
   - Do you have anal fissures of hemorrhoids?
   - Does anything make your bowels better or worse?

4. Please answer the following questions regarding your **SEXUAL** functioning:

   - Is intercourse painful (initial penetration and/or deep discomfort)?

   - Are you able to have an orgasm?

   - Do you experience pain or urinary or bowl symptoms during or after intercourse? If so, how long does it last?

5. How many physicians have you seen regarding this problem?

6. How long have you had your symptoms?

7. Please list all medications and amounts being taken.

8. Please list surgeries and medical interventions that you have undergone.