

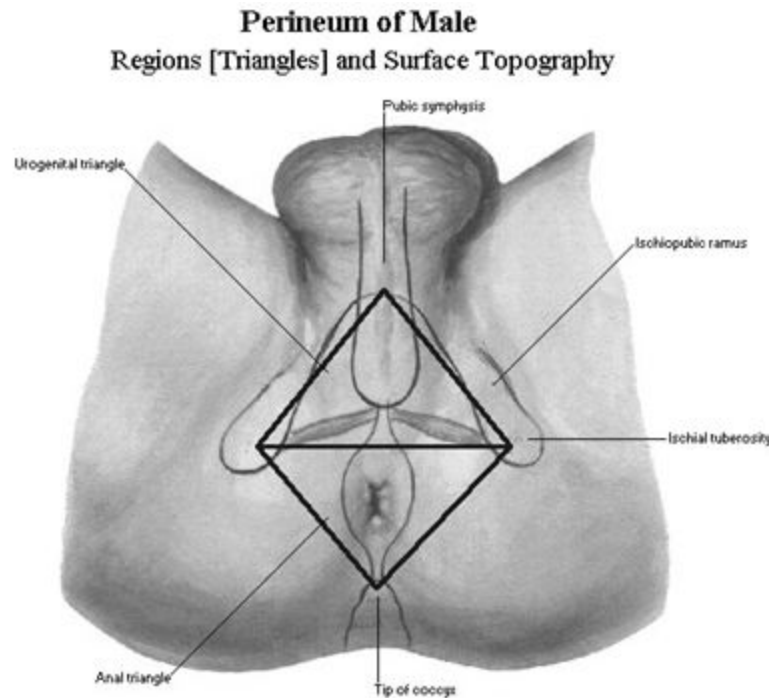
Male Intake Form

Name: _____

Today's date: _____

Date of birth: _____

Please mark If you are having pain (x) or tingling (-) in areas on this diagram



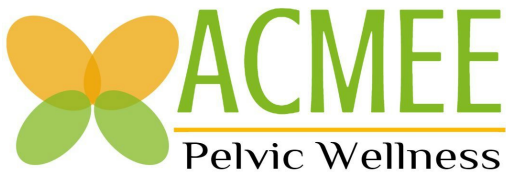
1. On a scale of 0-10 (0= no pain and 10 = emergency room pain) how much pain do you have

Current level? _____

When it's at the worst? _____

When it's at the best? _____

2. When did your symptoms start? _____



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3. What do you think caused your symptoms? _____

4. Have you been seen by other medical professionals for these symptoms? If so,
who and did they find a diagnosis or cause?

5. Have you had surgery that directly relates to your current symptoms? If so,
what type and when?

6. Out of 0--10 (0=no effect and 10 severe impairment), how much is your
problem affecting your quality of life? _____

7. Please answer the following questions regarding URINARY symptoms if
applicable:

a. Do you have difficulty initiating your stream? _____

b. Is the stream weak or interrupted? _____

c. How many times a day do you void? _____

d. How many times do you wake up at night to void? _____

e. Do you experience any pain before, during or after urinating?

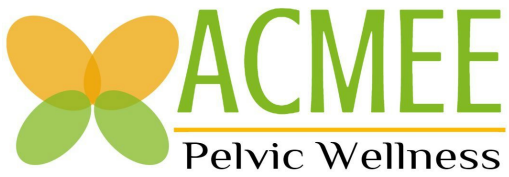
f. Any behaviors that aggravate the urinary symptoms? _____

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

8. Please answer these questions regarding your BOWEL habits:

a. Do you have a history of constipation? _____

b. How often do you have a bowel movement? _____



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c. Do you experience pain before, after or during a bowel movement?

d. Do you have anal fissures or hemorrhoids? _____

9. Please answer the following questions regarding **SEXUAL** functioning:

a. Are you able to have an erection? _____

b. Are you able to ejaculate? _____

c. Do you experience pain, urinary or bowel symptoms during or after ejaculation?
