

INTAKE FORM - MALE

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 or hemorrhoids?
- Does anything make your bowels better or worse?

