Physical Therapy Solutions
Solutions for an ACTIVE life

Patient History

Name _____ **Date** _____

Age: _____ **Primary Care:** _____

1. Describe the current problem that brought you here.

_____

2. When did your problem first begin?
   - ☐ _____ months ago
   - ☐ _____ years ago.

3. Was your first episode of the problem related to a specific incident?
   - ☐ Yes
   - ☐ No

Please describe and specify date:

_____

4. Since that time is it: staying the
   - ☐ same
   - ☐ getting worse
   - ☐ getting better

5. If pain is present rate pain on a 0-10 scale 10 being the worst. Describe the nature of the pain (i.e. constant burning, intermittent ache).

_____

6. Describe previous treatment/exercises

_____

7. Activities/events that cause or aggravate your symptoms. Check all that apply.
   - ☐ Sitting greater than __ minutes
   - ☐ Walking greater than __ minutes
   - ☐ Standing greater than __ minutes
   - ☐ Changing positions (ie. - sit to stand)
   - ☐ Light activity (light housework)
   - ☐ Vigorous activity/exercise (run/weight lift/jump)
   - ☐ Sexual activity
   - ☐ With cough/sneeze/straining
   - ☐ With laughing/yelling
   - ☐ With lifting/bending
   - ☐ With cold weather
   - ☐ With triggers -running water/key in door
   - ☐ With nervousness/anxiety
   - ☐ No activity affects the problem
   - ☐ Other, please list

Physical Therapy Solutions
Solutions for an ACTIVE life

8. What relieves your symptoms?

9. How has your lifestyle/quality of life been altered/changed because of this problem?

- ❑ Social activities (exclude physical activities), specify
- ❑ Diet /Fluid intake, specify
- ❑ Physical activity, specify
- ❑ Work, specify
- ❑ Other

11. What are your treatment goals/concerns?

Since the onset of your current symptoms have you had:

- ❑ Fever/Chills
- ❑ Unexplained weight change
- ❑ Unexplained muscle weakness
- ❑ Dizziness or fainting
- ❑ Night pain/sweats
- ❑ Change in bowel or bladder functions
- ❑ Malaise (Unexplained tiredness)
- ❑ Numbness / Tingling
- ❑ Other /describe

Health History: Date of Last Physical Exam

Tests performed

General Health: Circle what applies.

Excellent Good Average Fair Poor

Occupation

Hours/week On disability or leave? Activity Restrictions?

Mental Health:

Current level of stress:

- ❑ High
- ❑ Med
- ❑ Low

Current Mental Health Diagnosis:

- ❑ Anxiety

Physical Therapy Solutions
Solutions for an ACTIVE life

- ❑ Depression
- ❑ Other: _____

Activity/Exercise:

- ❑ None
- ❑ 1-2 days/week
- ❑ 3-4 days/week
- ❑ 5+ days/week

Describe :

Have you ever had any of the following conditions or diagnoses? circle all that apply /describe

☐ Cancer	☐ Stroke	☐ Emphysema/chronic bronchitis
☐ Heart problems	☐ Epilepsy/seizures	☐ Asthma
☐ High Blood Pressure	☐ Multiple sclerosis	☐ Allergies-list below
☐ Ankle swelling	☐ Head Injury	☐ Latex sensitivity
☐ Anemia	☐ Osteoporosis	☐ Hypothyroid/ Hyperthyroid
☐ Low back pain	☐ Chronic Fatigue Syndrome	☐ Headaches
☐ Sacroiliac/Tailbone pain	☐ Fibromyalgia	☐ Diabetes
☐ Alcoholism/Drug problem	☐ Arthritic conditions	☐ Kidney disease
☐ Childhood bladder problems	☐ Stress fracture	☐ Irritable Bowel Syndrome
☐ Depression	☐ Rheumatoid Arthritis	☐ Hepatitis HIV/AIDS
☐ Anorexia/bulimia	☐ Joint Replacement	☐ Sexually transmitted disease
☐ Smoking history	☐ Bone Fracture	☐ Physical or Sexual abuse
☐ Vision/eye problems	☐ Sports Injuries	☐ Raynaud's (cold hands and feet)
☐ Hearing loss/problems	☐ TMJ/ neck pain	☐ Pelvic pain
☐ Other/Describe		

Surgical /Procedure History

- ❑ Surgery for your back/spine
- ❑ Surgery for your brain
- ❑ Surgery for your female organs
- ❑ Surgery for your bladder/prostate
- ❑ Surgery for your bones/joints
- ❑ Surgery for your abdominal organs
- ❑ Other/describe

Ob/Gyn History (females only)

- ❑ Childbirth vaginal deliveries # _____
- ❑ Episiotomy # _____
- ❑ C-Section # _____
- ❑ Difficult childbirth # _____
- ❑ Prolapse or organ falling out
- ❑ Pelvic pain
- ❑ Vaginal dryness

Physical Therapy Solutions
Solutions for an ACTIVE life

- ☐ Menopause - when?
- ☐ Painful vaginal penetration
- ☐ Painful periods
- ☐ Other /describe

Males only

- ☐ Prostate disorders
- ☐ Shy bladder/Hard time starting urination
- ☐ Pelvic pain
- ☐ Erectile dysfunction
- ☐ Painful ejaculation
- ☐ Other /describe

Medications - pills, injection, patch Start date	Reason for taking:

Over the counter -vitamins etc	Start date	Reason for taking

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

- ☐ Trouble initiating urine stream
- ☐ Urinary intermittent /slow stream
- ☐ Difficulty stopping the urine stream
- ☐ Trouble emptying bladder completely
- ☐ Straining or pushing to empty bladder
- ☐ Dribbling after urination
- ☐ Constant urine leakage
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Trouble feeling bladder urge/fullness
- ☐ Recurrent bladder infections
- ☐ Current laxative use
- ☐ Trouble feeling bowel/urge/fullness
- ☐ Constipation/straining
- ☐ Trouble holding back gas/feces
- ☐ Other/describe

Physical Therapy Solutions
Solutions for an ACTIVE life

1. Frequency of urination: awake hour's____ times per day, sleep hours____times per night

2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?

- ❑ _____ minutes
- ❑ _____hours
- ❑ not at all

3. The usual amount of urine passed is:
- ❑ Small
- ❑ Medium
- ❑ Large

4. Frequency of bowel movements
   times per day _____
   times per week _____

5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
- ❑ minutes
- ❑ hours
- ❑ not at all

6. If constipation is present describe management techniques

7. Average fluid intake (one glass is 8 oz or one cup)
   _____ glasses per day.

   Of this total how many glasses are caffeinated?
   _____ glasses per day.

8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
- ❑ None present
- ❑ Times per month (specify if related to activity or your period)
- ❑ With standing for_____ minutes or _____ hours.
- ❑ With exertion or straining
- ❑ Other _____

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes
- ❑ No leakage
- ❑ Times per day
- ❑ Times per week
- ❑ Times per month
- ❑ Only with physical exertion/cough

Physical Therapy Solutions
Solutions for an ACTIVE life

9b. Bowel Leakage-number of episodes

- ❑ No leakage
- ❑ Times per day
- ❑ Times per week
- ❑ Times per month
- ❑ Only with physical exertion/cough

10a. On average, how much urine do you leak?

- ❑ No leakage
- ❑ Just a few drops
- ❑ Wets underwear
- ❑ Wets the floor

How much stool do you lose?

- ❑ No leakage
- ❑ Stool Staining
- ❑ Small amounts in underwear
- ❑ Complete emptying

11. What form of protection do you wear? (Please complete only one)

- ❑ None
- ❑ Minimal protection (Tissue paper/paper towel/pantishields)
- ❑ Moderate protection (absorbent product, maxipad)
- ❑ Maximum protection (Specialty product/diaper)
- ❑ Other _____
- ❑ On average, how many pad/protection changes are required in 24 hours? _____ # of pads