Personal Physical Therapy Services

Personal Issues... Personal Care

Patient History

Name _____ **Date**_____

1.Describe the current problem that brought you here? _____
_____
_____
_____

2. When did your problem first begin? _____

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 _____

Why or how? _____

5. Date of Last Physical Exam (for this problem) _____ Tests performed_____

6. Describe previous treatment/exercises_____

7. 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 _____

8. Activities/events that cause or aggravate your symptoms. Check/circle 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
___ Other, please list _____

___ 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

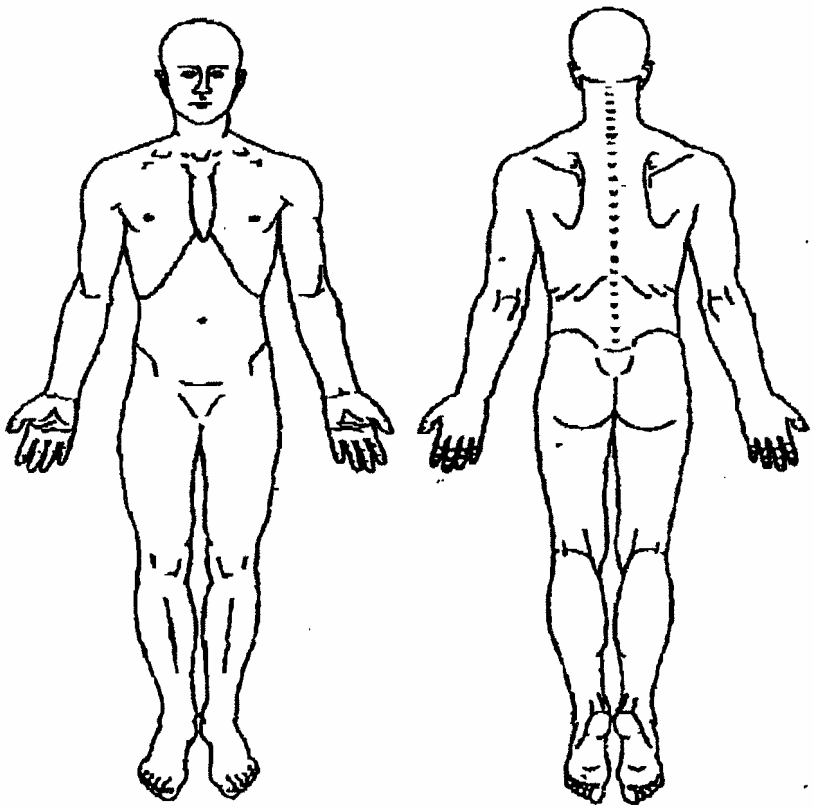
9. What relieves your symptoms? _____

10. What are your treatment goals/concerns? _____

Pg 2 History **Name** _____

11. Rate the severity of this problem from 0 -10 (0 being no problem and 10 being the worst)_____

Locate and draw your pain on the diagram below. Describe the nature of the pain (i.e. constant burning, intermittent ache)._____



Mark (/) across the line to indicate how bad your pain is **today** between the extremes of "No Pain At All" and "Pain As Bad As It Could Be".

No Pain At All _____ Pain As Bad As It Could Be

12. If pain is present rate pain on a 0-10 scale (10 being the worst). _____

Since the onset of your current symptoms have you had (check all that apply):

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

General Health: Excellent Good Average Fair Poor Occupation _____Hours/week_____
On disability or leave?_____ If yes, date started_____ Activity Restrictions? _____

Pg 3 History **Name** _____

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____

Mental Health: Current level of stress High__ Med___ Low___ Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply:

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	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/feet)	Hearing loss/problems
TMJ/ neck pain	Pelvic pain	Diabetes

Other/Describe_____

Surgical /Procedure History (check all that apply):

___ 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) (check all that apply):

___ Childbirth vaginal deliveries #_____
___ Episiotomy #_____
___ C-Section #_____
___ Difficult childbirth #_____
___ Prolapse or organ falling out
___ Other /describe_____
___ Vaginal dryness
___ Painful periods
___ Menopause - when? ____
___ Painful vaginal penetration
___ Pelvic pain

Males only (check all that apply):

___ Prostate disorders
___ Shy bladder
___ Pelvic pain
___ Other /describe_____
___ Erectile dysfunction
___ Painful ejaculation

Medications (if you have a list, it can be copied)- Reason for taking

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Over the counter – medications, vitamins, etc. Reason for taking

_____ _____
_____ _____

PELVIC SYMPTOM QUESTIONNAIRE

Bladder / Bowel Habits / Problems (check all that apply):

___ Trouble initiating urine stream
___ Urinary intermittent /slow stream
___ Trouble emptying bladder
___ Difficulty stopping the urine stream
___ Trouble emptying bladder completely
___ Straining or pushing to empty bladder
___ Dribbling after urination
___ Constant urine leakage
___ Other/describe_____

___ Blood in urine
___ Painful urination
___ Trouble feeling bladder urge/fullness
___ Current laxative use
___ Trouble feeling bowel/urge/fullness
___ Constipation/straining
___ Trouble holding back gas/feces
___ Recurrent bladder infections

1. Frequency of urination: during awake hours____ 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, or .
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

9b. Bowel leakage-number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount 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? _____