CORE essentials
PHYSICAL THERAPY AND PELVIC WELLNESS PLLC

Patient History

Patient Name_____ **DOB** _____ **Date** _____

Describe the current problem that brought you here?_____

_____

When did your problem first begin? _____ months ago or _____ years ago.

Was your first episode of the problem related to a specific incident? Yes / No

Please describe and specify date _____

_____

Since that time is it: staying the same _____ getting worse _____ getting better _____

Why or how? _____

What are your treatment goals/concerns? _____

_____

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) _____

_____

Describe previous treatment/exercises _____

_____

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 (i.e. sit to stand)
____ Light activity (light housework)
____ Vigorous activity/exercise (run/weight lift/jump)
____ Sexual activity
____ Other, please list _____

____ With laughing/yelling
____ With cough/sneeze/straining
____ With lifting/bending
____ With cold weather
____ With triggers (running water/key in the door)
____ With nervousness/anxiety
____ No activity affects the problem

_____

What relieves your symptoms?_____

_____

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 _____

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

Since the onset of your current symptoms have you had:

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

Health History: Date of Last Physical Exam _____ Tests performed_____

_____

General Health: Excellent Good Average Fair Poor

Occupation _____

Hours/week_____ On disability or leave?_____ Activity Restrictions? _____

Mental Health: Current level of stress: High_____ Med_____Low_____ Current psych therapy? Y / N

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

Other/Describe_____

Surgical /Procedure History

Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs

Other/describe_____

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Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #_____
Y/N Episiotomy #_____
Y/N C-Section #_____
Y/N Difficult childbirth #_____
Y/N Prolapse or organ falling out
Y/N Other /describe_____

Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when? _____
Y/N Painful vaginal penetration
Y/N Pelvic pain

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Other /describe_____

Y/N Erectile dysfunction
Y/N Painful ejaculation

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

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

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

1. Frequency of urination - 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.

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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? _____# of pads

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services with COREssentials Physical Therapy and Pelvic Wellness, PLLC.

Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____