Specialty Physical Therapy

To ensure that you receive a complete and thorough evaluation, please answer the following questions on this form. If you are unsure how to answer any questions, **please review them with your therapist at your first visit.**

Name: _____ Date of Birth: _____ Date of Appointment: _____

Gender at birth: _____ Gender identity: _____ Preferred pronoun: _____ Referring Physician: _____

Describe the reason for your appointment: _____ Date of onset: _____

Previous tests for this condition: _____

List activities that you cannot do because of this problem: _____

Are your symptoms?: ○ getting better ○ getting worse ○ staying the same

Medical History: Please check if you have ever had:

- ☐ Arthritis
- ☐ Broken bones/fractures
- ☐ Osteoporosis
- ☐ Circulation/vascular problems
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Diabetes
- ☐ Low blood sugar/hypoglycemia
- ☐ Head injury
- ☐ Pelvic Pain
- ☐ Sexual trauma or abuse
- ☐ Back Pain/back surgery
- ☐ Hip pain/hip surgery
- ☐ Neurological problems
- ☐ Allergies
- ☐ Thyroid problems
- ☐ Cancer _____
- ☐ Kidney problems
- ☐ Urinary Tract Infections
- ☐ Smoking habit
- ☐ Childhood bladder problems
- ☐ Blood in urine
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Ulcers/stomach problems
- ☐ Skin diseases
- ☐ Depression
- ☐ Blood clots
- ☐ Sexually transmitted infection
- ☐ Vaginal dryness
- ☐ Other_____

Surgeries/Hospitalizations: Please list any surgery or other condition for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization (or provide separate list):

_____

_____

_____

History of radiation and dates: _____

Ob/Gyn History: please check if you have ever had:

- ☐ Painful periods
- ☐ Difficult childbirth
- ☐ Number of: Vaginal deliveries: _____ C-sections: _____ Pregnancy Loss:_____ Termination:_____
- ☐ Menopause
- ☐ Proplapse or falling out feeling
- ☐ Painful penetration
- ☐ Episiotomy

Medications: Please list any medication, including the approximate start date and reason for taking medication (or provide separate list):

_____

_____

_____ _____

Other providers you are seeing for this condition? _____

Is this a work-related or auto injury? ○ yes ○ no

Have you seen a physical therapist this year? ○ yes ○ no If yes, how many visits have you had this year _____

May we obtain x-ray/MRI/CT scans/reports re: this condition? ○ yes ○ no

How did you hear about Specialty Physical Therapy? _____

Symptom Questionnaire: answer what applies, blanks are considered as does not apply

Bladder leakage

Frequency (chose one):

- ○ None
- ○ Constant
- ○ Not constant _____ per 24 hours: _____ per week _____ per month

Severity of leakage (choose one):

○ no leakage ○ few drops ○ Wets underwear ○ Wets outwear

Protection worn (choose all that apply):

- ☐ Tissue paper / paper towel
- ☐ Pantishield/ liner _____ shields used per 24 hours
- ☐ Incontinence pad _____ pads used per 24 hours
- ☐ Undergarment (Depends pants) _____undergarments used per 24 hours

Control of urinary urgency, how long can you delay (choose one)?

○ not at all ○ 1-2 min ○ 3-10 min ○ 11-30 min ○ 31-60 min ○ hours

Bowel leakage

Frequency (chose one):

- ○ None
- ○ Constant
- ○ Not constant _____ per 24 hours: _____ per week _____ per month

Severity of leakage (choose all that apply):

☐ smearing ☐ oozing ☐ loss of full BM ☐ incontinent of gas

Consistency of stool (choose all that apply):

☐ liquid ☐ soft unformed ☐ soft formed ☐ hard ☐ pellets

Protection used (choose all that apply):

- ☐ Plug
- ☐ Tissue paper / paper towel
- ☐ Pantishield / liners _____ shields used per 24 hours
- ☐ Incontinence pad _____ pads used per 24 hours
- ☐ Undergarment (Depends pants) _____undergarments used per 24 hours

Cause of bowel or bladder leakage (choose all that apply and type of incontinence)

☐ With strong cough/sneeze	☐ fecal ☐ urinary
☐ Vigorous activity or exercise (running, weight lifting)	☐ fecal ☐ urinary
☐ Light activity (walking, light housework)	☐ fecal ☐ urinary
☐ Changing positions (sit to stand)	☐ fecal ☐ urinary
☐ Walking to the toilet	☐ fecal ☐ urinary
☐ Strong urge to go	☐ fecal ☐ urinary
☐ Intercourse or sexual activity	☐ fecal ☐ urinary
☐ Dietary Changes	☐ fecal ☐ urinary
☐ No activity changes leakage (constant despite activity)	☐ fecal ☐ urinary
☐ Other, please list _____	☐ fecal ☐ urinary

Fluid intake (choose all that apply and enter number of glasses, where one glass is 8 oz. or one cup)

- ☐ Clear liquids _____ glasses per 24 hours
- ☐ Caffeinated _____ glasses per 24 hours
- ☐ Alcoholic _____ glasses per 24 hours
- ☐ Carbonated _____ glasses per 24 hours
- ☐ Containing artificial sweeteners _____ glasses per 24 hours

Bladder Habits (answer all)

- How often do you urinate? _____ times per 24 hours
- How often do you urinate after going to bed? _____ times
- Do you take your time to go to the toilet and empty your bladder? ○ yes ○ no
- Is the volume of urine passed usually; ○ large ○ average ○ small ○ very small
- Do you have the sensation that you need to go to the toilet? ○ yes ○ no
- Do you strain to pass urine? ○ yes ○ no
- Do you empty your bladder frequently, before you experience urgency? ○ yes ○ no
- Do you feel like you are able to empty your bladder completely? ○ yes ○ no
- Do you have a slow, interrupted, or hesitant urinary stream? ○ yes ○ no
- Do you have difficulty initiating the urine stream? ○ yes ○ no
- Indicate "triggers" that make you feel like you can't wait to go to the toilet.
  ☐ running water ☐ arriving home ☐ arriving at toilet ☐ rising from chair ☐ going out in the cold ☐ other_____

Bowel Habits (answer all)

- What is your frequency of bowel movements? _____times per 24 hours ____ times per week
- Do you have a history of constipation? ○ yes ○ no
- Do you currently strain to go? ○ yes ○ no
- Do you ignore the urge to defecate? ○ yes ○ no
- Do you have trouble making it to the toilet when you have an urge to go? ○ yes ○ no
- Do you have pain with bowel movements ○ yes ○ no

Pelvic Organ Prolapse (choose all that apply)

☐ None present
☐ Only with menstruation
☐ With standing
☐ With exertion or straining
☐ At the end of each day
☐ Present all day

Pelvic Pain

Location (choose all that apply):
☐ abdomen ☐ labia ☐ clitoris ☐ vagina ☐ anus/rectum ☐ bladder ☐ low back ☐ hips ☐ thighs

Frequency (chose one):
○ None
○ Constant
○ Not constant _____per 24 hours _____ per week

Quality of pain (choose all that apply):
☐ sharp ☐ dull ☐ pulsing/throbbing ☐ ache ☐ pressure ☐ other _____

Increased by (choose all that apply):
☐ exercise ☐ light activity ☐ vigorous activity ☐ arousal ☐ orgasm ☐ penetration ☐ GYN exam ☐ tampon use
☐ sitting ☐ standingwalking ☐ bowel movement ☐ urination ☐ stress

Decreased by (choose all that apply):
☐ rest/lying down ☐ heat ☐ ice ☐ stretching/exercise ☐ urination ☐ BM ☐ medication, indicate _____