



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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sexual trauma or abuse | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Back Pain/back surgery | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hip pain/hip surgery | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Ulcers/stomach problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Sexually transmitted infection |
| <input type="checkbox"/> Low blood sugar/hypoglycemia | <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Bacterial/Non-bacterial Prostatitis |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Smoking habit | <input type="checkbox"/> Benign Prostatic Hypertrophy (BPH) |
| <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Childhood bladder problems | <input type="checkbox"/> 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: _____

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 (choose one):

- a. None
- b. Constant
- c. Not constant _____ per 24 hours: _____ per week _____ per month

Severity of leakage (choose one):

- rb no leakage
- rb few drops
- rb Wets underwear
- rb Wets outwear

Protection worn (choose all that apply):

- 1. Tissue paper / paper towel
- 2. Shields _____ shields used per 24 hours
- 3. Incontinence/Guard pad _____ pads used per 24 hours
- 4. Undergarment (Depends pants) _____undergarments used per 24 hours

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

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

Bowel leakage

Frequency (choose one):

- B. None
- c. Constant
- d. Not constant _____ per 24 hours: _____ per week _____ per month

Severity of leakage (choose all that apply):

- cb smearing
- cb oozing
- cb loss of full BM
- cb incontinent of gas

Consistency of stool (choose all that apply):

- cb liquid
- cb soft unformed
- cb soft formed
- cb hard
- cb pellets

Protection used (choose all that apply):

- 1. Plug
- 2. Tissue paper / paper towel
- 3. Shields _____ shields used per 24 hours
- 4. Incontinence/Guard pad _____ pads used per 24 hours
- 5. Undergarment (Depends pants) _____undergarments used per 24 hours

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

- 1. With strong cough/sneeze cb fecal cb urinary
- 2. Vigorous activity or exercise (running, weight lifting) cb fecal cb urinary
- 3. Light activity (walking, light housework) cb fecal cb urinary
- 4. Changing positions (sit to stand) cb fecal cb urinary
- 5. Walking to the toilet cb fecal cb urinary
- 6. Strong urge to go cb fecal cb urinary
- 7. Intercourse or sexual activity cb fecal cb urinary
- 8. Dietary Changes cb fecal cb urinary
- 9. No activity changes leakage (constant despite activity) cb fecal cb urinary
- 10. Other, please list _____ cb fecal cb urinary

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

- 1. Clear liquids _____ glasses per 24 hours
- 2. Caffeinated _____ glasses per 24 hours
- 3. Alcoholic _____ glasses per 24 hours
- 4. Carbonated _____ glasses per 24 hours
- 5. 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? rb yes rb no
- Is the volume of urine passed usually; rb large rb average rb small rb very small
- Do you have the sensation that you need to go to the toilet? rb yes rb no
- Do you strain to pass urine? rb yes rb no
- Do you empty your bladder frequently, before you experience urgency? rb yes rb no
- Do you feel like you are able to empty your bladder completely? rb yes rb no
- Do you have a slow, interrupted, or hesitant urinary stream? rb yes rb no
- Do you have difficulty initiating the urine stream? rb yes rb no
- Indicate "triggers" that make you feel like you can't wait to go to the toilet.
cb running water cb arriving home cb arriving at toilet cb rising from chair cb going out in the cold cb 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? rb yes rb no
- Do you currently strain to go? rb yes rb no
- Do you ignore the urge to defecate? rb yes rb no
- Do you have trouble making it to the toilet when you have an urge to go? rb yes rb no
- Do you have pain with bowel movements rb yes rb no

Pelvic Pain

Location (choose all that apply):

cb abdomen cb scrotum cb penis cb anus/rectum cb bladder cb low back cb hips cb thighs

Frequency (choose one):

- None
- Constant
- Not constant _____ per 24 hours _____ per week

Quality of pain (choose all that apply):

cb sharp cb dull cb pulsing/throbbing cb ache cb pressure cb other _____

Increased by (choose all that apply):

cb exercise cb light activity cb vigorous activity cb erection cb ejaculation cb sitting cb standing/walking
cb bowel movement cb urination cb stress

Decreased by (choose all that apply):

cb rest/lying down cb heat cb ice cb stretching/exercise cb urination cb BM cb medication, indicate _____

Erectile Dysfunction

Difficulty (choose all that apply):

cb achieving an erection cb maintaining an erection cb with ejaculation

Medication (choose all that apply):

cb Cialis cb Viagra cb Levitra cb Other, indicate _____

Use of pump (choose one):

rb yes rb no