redbird physio

Name: _____ Height: _____

Date: _____ Weight: _____

In order to allow the therapist to have a better understanding of the nature of your symptoms & evaluate your condition fully, please complete the following questions as accurately as possible. Thank you!

1. Briefly describe how your symptoms began or how your condition occurred:

   _____

2. When did your symptoms first start (date)?

   _____

3. Since that time are your symptoms: ☐ The same ☐ Getting worse ☐ Getting better

4. If pain is present rate pain on a 0-10 scale 10 being the worst _____ Please briefly describe the nature of the pain (i.e. constant burning, intermittent ache) _____

5. Describe any previous treatment _____

6. 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 (ie light housework)

_____ Vigorous activity/exercise

_____ Sexual activity

_____ with cough/sneeze/straining

_____ with laughing/yelling

_____ with lifting/Bending

_____ with cold weather

_____ with triggers- ie running water/key in door

_____ with nervousness/anxiety

_____ No activity affects the problem

_____ Other, please list _____

7. What, if anything, relieves your symptoms? _____

8. My symptoms bother me: ☐ Constantly ☐ Most of the time ☐ Occasionally

9. Have you had a doctor's appointment for these symptoms? ☐ Yes ☐ No

If yes, when? _____

10. Have you had surgery for these symptoms? ☐ Yes ☐ No

If yes, when? _____

11. List 3 activities you are having difficulty doing as a result of your symptoms and rate on a scale of 0-10 (0 = unable to perform, 10 = no difficulty):

_____

_____

_____

12. What are your goals for physical therapy? _____

13. Please rate your overall health on a scale of 1-10 (1 = poor, 10 = excellent):

_____

14. Do you exercise? ☐ Yes ☐ No How many times a week do you exercise?

_____

15. Is there anything else about you or your symptoms that you would like us to know?

_____

_____

Medical History

☐ Allergies	☐ Dizzy Spells	☐ MRSA
☐ Anemia	☐ Emphysema/Bronchitis	☐ Multiple Sclerosis
☐ Anxiety	☐ Fibromyalgia	☐ Muscular Disease
☐ Arthritis	☐ Fractures	☐ Osteoporosis
☐ Asthma	☐ Gallbladder Problems	☐ Parkinson's Disease
☐ Autoimmune Disorder	☐ Headaches	☐ Rheumatoid Arthritis
☐ Cancer	☐ Hearing Impairment	☐ Seizures
☐ Cardiac Conditions	☐ Hepatitis	☐ Smoking
☐ Cardiac Pacemaker	☐ High Cholesterol	☐ Speech Problems
☐ Chemical Dependency	☐ High/Low Blood Pressure	☐ Strokes
☐ Circulation Problems	☐ HIV/AIDS	☐ Thyroid Disease
☐ Currently Pregnant	☐ Incontinence	☐ Tuberculosis
☐ Depression	☐ Kidney Problems	☐ Vision Problems
☐ Diabetes	☐ Metal Implants	☐ Other

Have you RECENTLY noticed any of the following:

☐ Weight gain/loss	☐ Nausea/Vomiting	☐ Weakness
☐ Impaired bowel/bladder function	☐ Night pain	☐ Dizziness
	☐ Fatigue	☐ Fever/Chills/Sweats

Fall History

Is this injury the result of a fall? ☐ Yes ☐ No

Have you had 2 or more falls in the past year? ☐ Yes ☐ No

If yes, please explain:

_____

Surgical History

Body Region: _____ Surgery Type: _____

Date: _____

Body Region: _____ Surgery Type: _____

Date: _____

Body Region: _____ Surgery Type: _____

Date: _____

Current Medications: Please provide a copy of your entire medication list

Drug: _____ Dosage: _____ Frequency: _____

Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____

Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____

Reason for Taking: _____

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, please 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

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1. Frequency of urination: awake hours _____ timer 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 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. Symptoms of 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 these 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 physical exertion/cough

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 use? (ie tissue paper, absorbent product)
    Please list: _____