OGDENCLINIC
PHYSICAL THERAPY

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Patient History

Name_____ **Date of Birth**_____ **Date**_____

1. Describe the current problem that brought you here? _____
   _____
2. When did your problem first begin? _____ Months ago or _____ years ago
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. If pain is present, rate pain on a 0-10 scale 10 being the worse _____
   Describe the nature of the pain (i.e. constant, burning, intermittent, ache) _____
   _____
6. Describe previous treatment/exercises _____
   _____
7. Activities/events that cause or aggravate your symptoms. Check 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 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

8. What relieves your symptoms? _____
9. 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_____
10. Rate the severity of this problem from 0-10. 0 being no problem and 10 being the worst _____
11. What are your treatment goals/concerns? _____
12. Since the onset of your current symptoms, have you had:

❑ Yes	❑ No	Fever/Chills	❑ Yes	❑ No	Malaise (Unexplained tiredness)
❑ Yes	❑ No	Unexplained weight change	❑ Yes	❑ No	Unexplained muscle weakness
❑ Yes	❑ No	Dizziness or fainting	❑ Yes	❑ No	Night pain/sweats
❑ Yes	❑ No	Change in bowel or bladder functions	❑ Yes	❑ No	Numbness/Tingling

Other/describe_____

Health History:

Date of Last Physical Exam_____ Tests Performed_____

General Health: ❑ Excellent ❑ Good ❑ Average ❑ Poor

Occupation_____ Hours/week_____On disability or leave? _____

Activity restrictions? _____

Mental Health:

Current level of stress: ❑ High ❑ Med ❑ Low Current phys therapy? ❑ Yes ❑ No

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? Check all that apply.

❑ Cancer
❑ Heart problems
❑ High Blood Pressure
❑ Ankle swelling
❑ Low back pain
❑ Sacroiliac/Tailbone pain
❑ Alcoholism/Drug problem
❑ Childhood bladder problems
❑ Depression
❑ Anorexia/bulimia
❑ Smoking history
❑ Vision/eye problems
❑ Hearing loss problems
❑ Stroke
❑ Multiple sclerosis
❑ Head injury
❑ Osteoporosis Chronic Fatigue
❑ Syndrome
❑ Fibromyalgia
❑ Arthritic conditions
❑ Stress fracture
❑ Rheumatoid Arthritis
❑ Joint Replacement
❑ Bone Fracture
❑ Sports Injuries
❑ TMJ/neck pain
❑ 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
❑ Emphysema/chronic bronchitis
❑ Asthma
Other: _____

Surgical /Procedure History

❑ Yes ❑ No Surgery for your back/spine
❑ Yes ❑ No Surgery for your brain
❑ Yes ❑ No Surgery for your female organs
❑ Yes ❑ No Surgery for your bladder/prostate
❑ Yes ❑ No Surgery for your bones/joints
❑ Yes ❑ No Surgery for your abdominal organs
Other _____
_____

Ob/Gyn History (Females only)

❑ Yes ❑ No Childbirth vaginal deliveries #___
❑ Yes ❑ No Episiotomy #___
❑ Yes ❑ No C-Section #___
❑ Yes ❑ No Difficult Childbirth #___
❑ Yes ❑ No Prolapse or organ falling out
❑ Yes ❑ No Vaginal dryness
❑ Yes ❑ No Painful periods
❑ Yes ❑ No Menopause – When? ____
❑ Yes ❑ No Painful vaginal penetration
❑ Yes ❑ No Pelvic pain
Other/Describe _____
_____

Males Only

❑ Yes ❑ No Prostate disorders
❑ Yes ❑ No Shy bladder
❑ Yes ❑ No Pelvic pain
❑ Yes ❑ No Erectile Dysfunction
❑ Yes ❑ No Painful ejaculation
Other/Describe _____
_____

Medications	Start Date	Reason for taking

Over the Counter- Vitamins, Etc.	Start Date	Reason for taking

Pelvic Symptoms Questionnaire

❑ Yes ❑ No Trouble initiating urine stream
❑ Yes ❑ No Urinary intermittent/slow stream
❑ Yes ❑ No Trouble emptying bladder
❑ Yes ❑ No Difficulty stopping the urine stream
❑ Yes ❑ No Trouble emptying bladder completely
❑ Yes ❑ No Straining or pushing to empty bladder
❑ Yes ❑ No Dribbling after urination
❑ Yes ❑ No Constant urine leakage
❑ Yes ❑ No Blood in urine

❑ Yes ❑ No Painful urination
❑ Yes ❑ No Trouble feeling bladder urge/fullness
❑ Yes ❑ No Current laxative use
❑ Yes ❑ No Trouble feeling bowel urge/fullness
❑ Yes ❑ No Constipation/straining
❑ Yes ❑ No Trouble holding back gas/feces
❑ Yes ❑ No Recurrent bladder infections
Other: _____
_____

1. Frequency of urination: awake hour's _____ times per day, sleep hours _____ times per night
2. When you have 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
8. Rate a feeling of organ "falling out" / prolapsed 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

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
___Wet underwear
___Wet outerwear
___Wets the floor

10b. How much stool do you lose?
___No leakage
___Stool straining
___Small amount in underwear
___Complete emptying

1. 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: _____
2. On average, how many pad/protection changes are required in 24 hours? _____ # of pads
3. Are you sexually active? Yes ❏ No ❏
4. Are you pregnant or attempting pregnancy? Yes ❏ No ❏
5. Number of pregnancies?_____ Complications _____
6. History or present sexually transmitted diseases? Type _____
   _____
7. Do you have pain or problems with sexual activity or urination?
8. Describe_____
   _____
9. Have you ever been taught or prescribed to do pelvic floor/Kegel exercises?
10. Yes ❏ No ❏ When? _____ By Whom? _____
11. How often do you do pelvic floor exercises? _____
    Any comments or concerns not asked? _____
    _____
    _____
    _____
    _____