Lawrence County

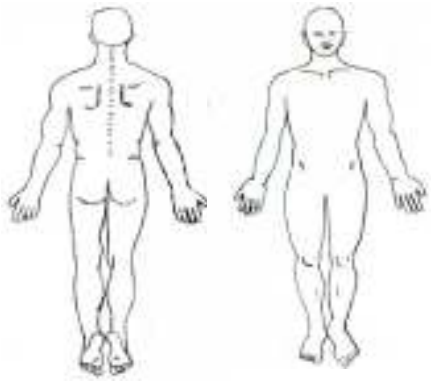
Physical Therapy Institute

PATIENT HISTORY:

Chief Complaint: _____

When did your symptoms start: _____

Are your symptoms getting: better, worse or staying the same (circle one)



PAIN:

Please draw the location and type of your pain:

Pins and Needles **^^^^** Stabbing **////**

Numbness **o o o** Burning **x x x**

Ache ******** Other **- - -**

Please rate you current pain (1-10): _____

At the best in last 24 hours (1-10): _____

At the worst in last 24 hours (1-10): _____

FUNCTIONAL RATING:

Please rate at what percent you are able to function prior to your condition (0-100%): _____

Please rate at what percent you are able to function because of your current condition (0-100%): _____

Please describe activities or things you cannot do because of the above problem: _____

_____

MEDICAL HISTORY:

Please list all PRESCRIPTION medication and vitamins that you are currently taking: _____

_____

Please list all pelvic and abdominal surgeries with dates of operation: _____

_____

Date of last pelvic examination: _____ Date of last urinalysis: _____

Any other special tests performed: (provide date and type) _____

_____

Have you or any member of your family EVER been diagnosed with any of the following, if **YES please indicate you or family**.

			Comments/Details:				Comments/Details:
Cancer	YES	NO	_____	Arthritis Condition	YES	NO	_____
Heart Attack	YES	NO	_____	Depression	YES	NO	_____
Pacemaker	YES	NO	_____	Hepatitis	YES	NO	_____
High Blood Pressure	YES	NO	_____	High Cholesterol	YES	NO	_____
Low Blood Pressure	YES	NO	_____	Stroke	YES	NO	_____
COPD	YES	NO	_____	Anemia	YES	NO	_____
Emphysema	YES	NO	_____	Multiple Sclerosis	YES	NO	_____
Allergies or Sensitivities	YES	NO	_____	Other _____			

Are you sexually active? YES/NO (please circle)

Are you pregnant or attempting pregnancy? YES/NO (please circle)

Number of pregnancies _____Number Delivered _____Delivery method_____

Did you have an episiotomy or tearing with delivery? _____

Any complications? _____

_____

History of or present sexually transmitted diseases? (YES/NO) Type: _____

_____

Do you have pain or problems with sexual activity or urination? _____

_____

Have you ever been taught or prescribed to do pelvic floor/Kegel exercises? (YES/NO)

When? _____ By who? _____

How often do you do pelvic floor exercises? _____

What would you like to accomplish with PT? _____

Any comments or concerns not asked. _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY (circle best answer)

1. OCCURANCE OF INCONTINENCE OR LEAKAGE
   - Never
   - Less than 1/month
   - More than 1/month
   - Less than 1/week
   - More than 1/week
   - Almost every day
   - # _____ per day

2. PROTECTION USED TO PREVENT LEAKAGE
   - No protection
   - Pantishields
   - Mini pads
   - Maxi pad
   - Bladder control pad type_____
   - Diaper

3. SEVERITY
   - No leakage
   - Few Drops
   - Wet underwear
   - Wet outerwear

4. POSITION OR ACTIVITY WITH LEAKAGE
   - Lying down
   - Sitting
   - Standing
   - Changing positions (sit to stand)
   - Sexual activity
   - Strong Urge

5. HOW LONG CAN YOU DELAY THE NEED TO URINATE
   - Indefinitely
   - 1+ hours
   - ½ hour
   - 15 minutes
   - Less than 10 minutes
   - 1-2 minutes
   - Not at all

6. ACTVITY THAT CAUSES URINE LOSS
   - Vigorous activity
   - Moderate activity
   - Light activity
   - No activity
   - Type: _____

7. PROLAPSE: (Falling out feeling)
   - Never
   - Occasionally/with menses
   - Pressure at the end of the day
   - Pressure with straining
   - Pressure with standing
   - Perineal pressure all day

8. FLUID INTAKE
   - Includes water and beverages
   - 9+ 8 oz glasses per day
   - 6-8 8 oz glasses per day
   - 3-5 8 oz glasses per day
   - 1-2 8 oz glasses per day
   - How many caffeinated glasses?_____

9. FREQUENCY OF URINATION (DAYTIME)
   - 0 times per day
   - 1-4
   - 5-8
   - 9-12
   - 13+

10. FREQUENCY OF URINATION (NIGHTIME)
    - 0 times per night
    - 1-4
    - 5-8
    - 9-12
    - 13+

11. FREQUENCY OF BOWEL MOVEMENTS
    - 2 x per day
    - 1 time per day
    - Every other day
    - Once every 4-7 days
    - Weekly

12. DO YOU HAVE TROUBLE INITIATING URINE STREAM?
    - Never
    - More than once a month
    - Less than 1/month
    - Almost every day

13. AFTER STARTING TO URINATE, CAN YOU COMPLETELY STOP FLOW OF URINE?
    - Can stop completely
    - Can maintain a slowing of the stream
    - Can partially slow the urine stream
    - Unable to deflect or slow the stream

14. ATTITUDE TOWARDS PROBLEM
    - No problem
    - Minor inconvenience
    - Slight problem
    - Moderate problem
    - Major problem

15. CONFIDENCE IN CONTROLLING YOUR PROBLEM
    - Complete confidence
    - Moderate confidence
    - Little confidence
    - No confidence