

NAME: _____ DATE: _____

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

Describe your main problem? _____

When did your symptoms begin? _____

Which of the following **best describes** how your injury occurred?

- | | |
|---|---|
| <input type="checkbox"/> (1) childbirth | <input type="checkbox"/> (7) car accident |
| <input type="checkbox"/> (2) after surgery | <input type="checkbox"/> (8) trauma |
| <input type="checkbox"/> (3) a fall | <input type="checkbox"/> (9) running |
| <input type="checkbox"/> (4) lifting | <input type="checkbox"/> (10) unknown |
| <input type="checkbox"/> (5) degenerative process | <input type="checkbox"/> (11) other _____ |
| <input type="checkbox"/> (6) during recreation/sports | |

Since onset, are your symptoms getting: (Check one)

- (1) better (2) worse (3) not changing

Which of the following best describes the nature of your symptoms? (Check all that apply)

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> (1) sharp | <input type="checkbox"/> (7) throbbing | <input type="checkbox"/> (13) aching |
| <input type="checkbox"/> (2) stabbing | <input type="checkbox"/> (8) splitting | <input type="checkbox"/> (14) occasional |
| <input type="checkbox"/> (3) constant | <input type="checkbox"/> (9) cramping | <input type="checkbox"/> (15) n/a |
| <input type="checkbox"/> (4) dull | <input type="checkbox"/> (10) itching | <input type="checkbox"/> (16) other _____ |
| <input type="checkbox"/> (5) shooting | <input type="checkbox"/> (11) tender | |
| <input type="checkbox"/> (6) gnawing | <input type="checkbox"/> (12) hot/burning | |

Describe activities that you cannot do because of your problem

Last Pelvic Exam (date) _____

Last Urinalysis (date) _____

Other Special Tests (Specify date, type, results) _____

Are you sexually active? (1) No (2) Yes

Pain or problems with sexual activity? _____

History of/or present sexually transmitted diseases?

(1) No (2) Yes Type: _____

WOMEN -- Are you pregnant or attempting pregnancy?

(1) No (2) Yes

of vaginal deliveries _____ # of Cesarean deliveries _____

Complications from childbirth? _____

Do you have any of the following (check all that apply)

- (1) difficulty initiating a stream/bowel movement
- (2) no perception of bladder fullness
- (3) weak, slow or intermittent stream of urine
- (4) frequent toileting to avoid problems
- (5) dribbling after stream ends
- (6) pain/burning during urination/defecation
- (7) blood in stool/urine
- (8) n/a

1. Occurrence of incontinence or leakage (if this does not apply skip to question #4)

- (1) times a day _____ (2) times a week _____
 (3) times a month _____

2. Severity of Leakage

- (1) no leakage (4) wet outerwear
 (2) few drops (5) other _____
 (3) wet underwear

3. Position or activity with leakage

- | | |
|--|--|
| <input type="checkbox"/> (1) no leakage | <input type="checkbox"/> (8) coughing |
| <input type="checkbox"/> (2) lying down | <input type="checkbox"/> (9) sneezing |
| <input type="checkbox"/> (3) sitting | <input type="checkbox"/> (10) laughing |
| <input type="checkbox"/> (4) standing | <input type="checkbox"/> (11) changing positions |
| <input type="checkbox"/> (5) walking | <input type="checkbox"/> (12) sexual act |
| <input type="checkbox"/> (6) running | <input type="checkbox"/> (13) when constipated |
| <input type="checkbox"/> (7) strong urge | <input type="checkbox"/> (14) on way to toilet |

4. Prolapse (feeling of falling out)

- | | |
|---|--|
| <input type="checkbox"/> (1) never | <input type="checkbox"/> (4) pressure with straining |
| <input type="checkbox"/> (2) occasionally/with menses | <input type="checkbox"/> (5) pressure with standing |
| <input type="checkbox"/> (3) pressure at end of day | <input type="checkbox"/> (6) pressure all day |

5. How long can you delay the need to eliminate?

- | | |
|---|---|
| <input type="checkbox"/> (A) Bowel | <input type="checkbox"/> (B) Bladder |
| <input type="checkbox"/> (1) indefinitely | <input type="checkbox"/> (5) less than 10 minutes |
| <input type="checkbox"/> (2) 1+ hours | <input type="checkbox"/> (6) 1-2 minutes |
| <input type="checkbox"/> (3) ½ hour | <input type="checkbox"/> (7) not at all |
| <input type="checkbox"/> (4) 15 minutes | |

6. Ability to stop urine flow

- (1) can stop completely
 (2) can maintain a deflection of the stream
 (3) can partially deflect urine stream
 (4) unable to deflect or slow the stream
 (5) other _____

7. Fluid Intake _____ 8 oz. glasses per day

Caffeinated beverages _____ glasses per day

8. Frequency of bowel movements _____ times per week

9. If you are experiencing pain, do your symptoms wake you at night? (1) No (2) Yes (3) N/A

if "yes", is it present

- (1) while lying still (2) changing positions (3) both

10. What aggravates your symptoms? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> (1) sitting | <input type="checkbox"/> (11) menstruation |
| <input type="checkbox"/> (2) squatting | <input type="checkbox"/> (12) sustained bending |
| <input type="checkbox"/> (3) standing | <input type="checkbox"/> (13) taking a deep breath |
| <input type="checkbox"/> (4) sleeping | <input type="checkbox"/> (14) going to/from sitting |
| <input type="checkbox"/> (5) sexual activity | <input type="checkbox"/> (15) coughing/sneezing |
| <input type="checkbox"/> (6) lying | <input type="checkbox"/> (16) stress |
| <input type="checkbox"/> (7) walking | <input type="checkbox"/> (17) not applicable |
| <input type="checkbox"/> (8) exercises including | <input type="checkbox"/> (18) other _____ |

(9) repetitive activities including _____

11. What relieves your symptoms? (Check all that apply)
- (1) sitting
 - (2) heat
 - (3) cold
 - (4) stretching
 - (5) rising from sitting
 - (6) rest
 - (7) standing
 - (8) walking
 - (9) exercise
 - (10) lying down
 - (11) massage
 - (12) medication
 - (13) nothing
 - (14) other _____

12. Have you had any previous treatment for this condition? (Check all that apply)
- (1) none
 - (2) laser
 - (3) TENS unit
 - (4) surgery
 - (5) dietary changes
 - (6) physical therapy
 - (7) electrical stimulation
 - (8) injection into the skin/muscles
 - (9) pelvic floor exercises
 - (10) biofeedback
 - (11) joint manipulation
 - (12) ultrasound
 - (13) injection into the spine
 - (14) overnight hospitalization
 - (15) other _____

Any other concerns not addressed? _____

MEDICATION

In the last 4 weeks have you taken any medication for your current symptoms? (1) Yes (2) No
List: _____

Please list any other prescription medications you are currently taking (*pain pills, injections and/or skin patches etc.*):

Are you currently taking any of the following over the counter medications?

- (1) aspirin
- (2) Tylenol
- (3) corticosteroids
- (4) antihistamines
- (5) Vitamins/mineral supplements
- (6) Advil/Motrin/Ibuprofen
- (7) other _____

PREVIOUS FUNCTIONAL LEVEL

Independent in all activities (work, community, home, recreation)

Self Care

- Independent in all self-care (bathing, toileting, dressing, etc.) activities
- Have difficulty performing self-care activities
- Need assistance with self-care activities
- Have difficulty performing household chores

Social

Need assistance with activities in community outside of home

Hobbies: _____

WORK HISTORY

Occupation

- (1) employed full time
- (2) employed part time
- (3) self employed
- (4) homemaker
- (5) student
- (6) retired
- (7) unemployed
- (8) other _____

Physical activities at work

- (1) sitting
- (2) heavy lifting
- (3) repetitive lifting
- (4) computer use
- (5) heavy equipment operation
- (6) driving
- (7) other _____

Are you currently receiving for seeking disability for this condition?
 Yes No

If not performing your normal activities at work do you plan to RETURN to your previous activity level? Yes No

LIVING SITUATION

- live alone
- live with caregiver
- live with family member/others
- home/apartment
- retirement complex (SNF/ ICF)
- assisted living complex
- other _____

Setting

- stairs
- uneven ground
- stairs with railing
- ramp
- elevator
- other _____

GENERAL HEALTH

How would you rate your general health?

- Excellent
- Good
- Average
- Fair
- Poor

Do you exercise outside of normal daily activities?

- (1) 5+days/wk
- (2) 3-4 days/wk
- (3) 1-2days/wk
- (4) occasionally
- (5) zero

Exercise consisting of _____

Do you smoke?

- No
- Yes _____ packs of cigarettes a day

What is your stress level?

- Low
- Medium
- High

Are you seeing any health care providers other than the physical therapist for this current condition?(list) _____

MEDICAL HISTORY

Have you ever had/ been diagnosed with any of the following conditions?

- Cancer (type) _____
- Depression
- Stroke
- Kidney Problems
- Thyroid problems
- Diabetes
- Multiple Sclerosis
- Arthritis
- Head Injury
- Circulation/vascular problems
- Parkinson's Disease
- Infectious Diseases (i.e. hepatitis, tuberculosis)
- Heart Problems
- High blood pressure
- Lung Problems
- Blood Disorders
- Epilepsy/Seizures
- Allergies
- Rheumatoid arthritis
- Osteoporosis
- Broken bone
- Stomach problems
- Other _____

List pelvic/abdominal or bowel/bladder surgeries with dates of operation

SURGERY

DATE

FAMILY HISTORY

Has anyone in your immediate family (*parents, brothers, sisters*) ever been treated for any of the following?

- Diabetes
- Heart disease
- High blood pressure
- Stroke
- Other _____
- Cancer
- Arthritis
- Osteoporosis
- Psychological Condition