Your next appointment is on _____, _____at _____ AM/PM

Please fill out the attached form and bring it with you on your next appointment or return it via e-mail.

I appreciate you taking this extra time to answer the questions. It lets us focus the whole appointment on the actual treatment!

1. Did you notice any changes/reaction during the first 24-36 hours after you had the last P.T. treatment?

2. As of now the moment in which you are filling out this questionnaire, did your symptoms that brought you here change?

3. Are you able to perform/participate in activities that you before could not?

4. Did the behavior or intensity of your pain/discomfort change?

5. Did your mobility change?

PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name: **Age:__ Why are you here?_**

Check all the Conditions that apply to you:

HEART/CIRCULATION	√	MEDICAL PROBLEMS	√	CHILDBEARING HISTORY	
Heart disease/Surgery		Diabetes		Is chance you are pregnant/Are you trying to become Preqnant? Yes No	
High blood pressure		Cancer		Are you Pregnant? Yes No 1 Due date	
Pain/Tightness in chest		Thyroid		# of Children (circle)	**0 12 3 4 5+**
Pacemaker		Autoimmune disease		# of Vaginal Deliveries	**0 12 3 4 5+**
Cold hands/Feet		Depression		#of C-Sections	**0 12 3 4 5+**
Numbness hands/Feet		Hepatitis		# of Episiotomies	**0 12 3 4 5+**
Ankle swelling		Bulimia/Anorexia		# of Forceps Deliveries	**0 12 3 4 5+**
Stroke		Acid reflux/Belching		Birth weight of largest baby lbs. oz.	
BONES & JOINTS		**LUNG/BREATHING**		**GYNECOLOGICAL HISTORY**	
History of whiplash		Emphysema/Bronchitis		Date of last pap smear?	
Chronic fatigue		Asthma		Do you have pain with sexual intercourse?	Yes No NA
Arthritis		Smoking history		History of/Current Candida/Genital herpes/Yeast?	Yes No
Fibromyalgia		Shortness of breath		Sexually transmitted disease	Yes No
Tailbone pain		**SURGICAL HISTORY**		Do you use vaginal sprays/Deodorants, Bath salts?	Yes No
Joint replacements		Back or neck		Do you use vaginal lubricants or KY jelly?	Yes No
Metal plates/Screws		Tubal Litigation		Do you use latex condoms?	Yes No
Osteoporosis		Laproscopy		**URINARY BLADDER HISTORY** **Do you have**.....	
Fracture		Abdominal Hysterectomy		bladder pain?	Yes No
TMJ/Neck pain		Vaginal Hysterectomy		burning with urination?	Yes No
MENTAL HEALTH		Gall Bladder		feeling of pressure in bladder?	Yes No
Current psych therapy		Bladder Surgery		interstitial cystitis?	Yes No
Level of stress H/M/L		Pelvic Surgery		trouble starting urine stream?	Yes No
NERVIOUS SYSTEM		Vulvar Surgery		frequent bladder infections?	
Epilepsy		Pudendal Nerve Surgery		Have you had 1 or more urethral dialations?	
Multiple Sclerosis				Do you have a falling out feeling? Yes No	
Head Injury		**FALLS/TRIPS/SLIPS**		If yes __ Sometimes with menses__ Standing __ Straining	
ALLERGIES		Dizziness		_____ All at the end of the day __All the time	
Latex sensitivity		# of Falls last 6 Months		**BOWEL HISTORY**	
Seasonal		Fall onto Hips/Sitting Bone/Tailbone		Do you leak gas or feces?	Yes No
Food				Do you have constipation?	Yes No
				Do you strain to have a bowel movement?	Yes No
				How often do you have a bowel movement? 2 or more	
				times per day daily every other day every 4-7 days	

LIST ALL THE MEDICATIONS YOU ARE TAKING. INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS & PATCHES:

Name of Medication	For What?	Name of Medication	For What?

IF YOU HAVE PELVIC AND/OR SEXUAL DISCOMFORT, PLEASE COMPLETE THIS PAGE

CURRENT SEXUAL ACTIVITY:
_ Sexually inactive due to PAIN __ Sexually inactive due to bladder problem _ Sexually active

If you are sexually active, continue with this section
_ No pain with intercourse __ Pain with intercourse, unable to complete coitus __Pain with intercourse disrupts or prevents coitus __Pain with intercourse prevents any attempt at coitus

CHECK THE WORDS THAT DESCRIBE YOUR PAIN: ___No Pain or pain is:
_ Hot__ Burning _ Searing __ Sharp __ Tiring __ Exhausting __Frightful__ Pushing __ Annoying __Troublesome
_ Miserable __Intense __ Unbearable __ Discomforting __Other _____

WHAT MAKES YOUR PAIN BETTER: _No pain, or pain is relieved with:
_ Heating pad__ Ice pack__ Resting in bed __Resting in chair _ Medication__ Cream _____
_Abstaining from sexual intercourse __Not using tampons__ Not wearing tight clothes __Other _____

What started this problem?_____

Comments _____

Anything else you would like us to know about you?

SYMPTOMS OF URINARY INCONTINENCE AND / OR PROLAPSE

PLEASE COMPLETE BY INDICATING THE NUMBER THAT BEST DESCRIBES YOUR SYMPTOMS IN THE FIRST COLUMN

Measures for urinary incontinence	**DATE**				**GOAL**	**#WEEKS**
Frequency of leakage: 0=never 1=1-4 x month 2=2-4 x week 3=once a day 4=more than once a day						
Quantity of leakage: 0=none 1=few drops 2=soak liner/underwear 3=soak pad outerwear 4=runs down my leg						
Type of protection used: 0=none 1=panty liner 2=min pad 3=maxi pads 4=Poise/Depends						
Number of pads: 0=none 1=with some activity 2=1xday 3=2-4xday 4=more than 4xday						
Activities causing leakage: 0=none 1=light 2=moderate 3=vigorous 4=all physical activity						
Measures for frequency: 0=no problem 1=very small 2=small 3=medium 4=big problem						
Frequency of urination, voiding interval £ 2 hours						
Nocturna (0-2 per night)						
Frequency as noted by bladder diary_ subjective (state as number of voids per day)						
Nocturna as noted by_ bladder diary_ subjective (state as number of voids per day)						
Measures for urgency: 0=no problem 1=very small 2=small 3=medium 4=big problem						
Need to urinate with no warning: Rate as a problem 0-4						
Urgency associated with leakage						
Measures for bladder discomfort: 0=no problem 1=very small 2=small 3=medium 4=big problem						
Bladder burning						
Bladder discomfort						
Bladder pain						
Bladder pressure						
Effect of problem on daily life 0=no problem 1=very small 2=small 3=medium 4=big problem						
Affects choice of clothing^						
Affects ability for housework						
Ability to travel more than one hour without using bathroom						
Interferes with social activities						
Affects sex life/relationship wih partner						
Patient feels depressed, anxious, embarrassed, frustrated, angry						
Worries that she smells						
Withholds fluids for fear of leakage or frequency						
Lifestyle changes (within scope of PT practice)						
Exercise increase in activity level weight management						
Use of pelvic floor muscles with increase in abdominal pressure						
Increase water intake change type of fluid change diet						
Other						

1. 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 position (i.e. sit to stand)
Light activity (light housework)
Vigorous activity/exercise (run/weight lift/jump)

_Other_____
_With cough/sneeze/straining
_With laughing/yelling
_With lifting/bending
_With cold weather
_With triggers i.e. /key in door

SOCIAL. OCCUPATIONAL AND RECREATIONAL ACTIVITIES

Marital Status: _ Single__ Married _ Separated __ Divorced __ Dating

Do vou feel safe at home?: _ Yes__ No Comments: _____

Occupation:_____ Physically this means I _ sit __stand __walk most of the day.

Education Level: _____ Hobbies:_____

EXERCISE HISTORY:
_ No exercise _ Walk _____ Go to gym.
Other_____

CHECK THE WORDS THAT APPLY TO HOW YOU FEEL THESE DAYS:

DESCRIPTOR													
Happy		Calm		Unmotivated		Stressed		Lonely		Content		"Post partum blues"	
Overwhelmed		Sad		Tired		Afraid		Energetic		Optimistic			
Flabby		Strong		Unrested		Lethargic		Weak		Overworked		Not bonding with baby	
Anxious		Unsafe		Abused		Neglected		Depressed					

HOW DO YOU LEARN?: ___ Listening (lecture, discussion) ___Seeing (read, video, DVD) __Doing (practicing skills)

Is English your primary language? __Yes _ No If no, would you need a translator when you are in therapy?

NUTRITION How much do you weigh? pounds

Would you like to loose or qain weight	Yes No	
Have you gained/lost more than 10 lbs in the last year?	Yes No	
Are you on a special diet?	Yes No	__ Low carb___Weight Watchers ___ South Beach Atkins Diabetic Other:
Would you say your diet is unhealthy?	Yes No	__ Too many fast foods___Not enough vegetables High fat High Carb Other.

FLUID INTAKE: What do you drink every day?
__8 ounce glasses of water__ cans of diet soda __ 8 ounce cups of regular coffee
_ 8 ounce cups of decaffeinated coffee __ 8 ounce cups/glasses of tea__ 16 ounce cans of beer
_ glasses of wine glasses of liquor___ 8 ounce glasses of milk __8 ounce glasses of juice _____
Other _____

WHAT TREATMENTS HAVE YOU HAVE FOR THIS PROBLEM? None or:

TREATMENTS	HAS IT HELPED?	TREATMENTS	HAS IT HELPED?
Medication	Yes No A little	Surgery	Yes No A little
Physical Therapy	Yes No A little	Other:	Yes No A little

Since the onset of your current symptoms, have you had?

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y / N Change in bowel or bladder functions
Y / N Other/describe _____
Y / N Malaise (unexplained tiredness)
Y / N Unexplained muscle weakness
Y / N Night pain/sweats
Y / N Numbness/tingling

Date of last physical exam.
Tests performed _____