QUEEN CITY PELVIC PT
The Professional and Personal Care You Deserve

Patient History

Patient Name _____ **DOB**_____ **Date**_____
Email:_____ Telephone:_____

Please describe the problem or symptoms that brought you here._____
_____
_____
When did your symptoms first begin? _____
Is there a specific event that you associate with the onset of your symptoms? If so, describe
_____
_____
Since that time, are your symptoms: ☐ staying the same ☐ getting worse ☐ getting better
How so? _____

What health care providers have you seen for your symptoms? _____
_____
Describe previous medications/treatment/exercises that you have tried for your symptoms and whether or not they were helpful: _____
_____
_____
What do you think is causing your problem? _____
_____
_____

Functional Impact:
Please check any activities/events that cause or aggravate your symptoms.

☐ Sitting greater than _____ minutes
☐ Standing greater than _____minutes
☐ Walking greater than _____ minutes
☐ Changing positions (i.e. - sit to stand)
☐ Light activity (light housework, walking)
☐ Vigorous activity/exercise (run/weight lift/cleaning)
☐ Sexual activity
☐ Other, please list_____
☐ cough/sneeze/laughing
☐ With nervousness/anxiety
☐ lifting/bending/straining
☐ cold weather
☐ triggers -running water/key in door
☐ No activity affects the problem

What relieves your symptoms? _____
_____

Has your lifestyle/quality of life been affected by your symptoms?
What activities have you altered or avoided because of this problem?
Physical activities: _____
Social activities: _____
Diet /Fluid intake: _____
Work activities: _____
Other: _____

Rate the severity of the ***impact of your symptoms on your life*** from 0 -10 (0 being no problem and 10 worst) _____
If pain is present, rate ***pain*** on a 0-10 scale (10 being the worst)
Average: _____ Best: _____ Worst: ____
Describe the ***location*** of the pain: _____
_____
Describe the ***nature*** of the pain (i.e. constant burning, intermittent ache)_____
_____

Please list your top three goals for therapy:

1. _____
2. _____
3. _____

(For office use only: PSFS score _____ / _____)

Lifestyle and Health Habits
Occupation: _____Hours/week_____ on disability or leave? _____
Please list any activity restrictions. _____
Whom do you live with? _____

Aerobic Activity/Exercise: ☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5+ days/week
Describe: _____
Do you: ☐ Smoke ☐ Drink alcohol ☐ Recreational drugs?
What is your average fluid intake per day? (one glass is 8 oz or one cup) _____ glasses/day.
Of this total, how many glasses are caffeinated? _____ glasses per day.
How would you describe your diet? ☐ Excellent ☐ Average ☐ Poor ☐ Vegan ☐ High fiber
☐ food restrictions: _____
Please list any allergies: _____

Mental Health: Current level of stress: ☐ High ☐ Med ☐ Low
Have you ever experienced ☐ physical ☐ verbal ☐ sexual or ☐ emotional abuse?
☐ Or been forced to do something that you did not want to?
Have you had counseling or psychological therapy? ☐ Never ☐ In the past ☐ Currently
How would you describe your support system? ☐ Amazing ☐ Fair ☐ Poor ☐ Non-existent

How would you describe your overall health?
☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Males only: Check all that apply

☐ Prostate disorders	☐ Erectile dysfunction
☐ Shy bladder	☐ Painful ejaculation
☐ Pelvic pain	☐ Other /describe_____

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Health History:

PCP: _____ **Referring MD**: _____

Date of Last Physical Exam: _____ Tests performed: _____

_____

Have you ever had any of the following conditions or diagnoses? Check all that apply

☐ Cancer	☐ Stroke	☐ Pelvic pain
☐ Heart problems	☐ Epilepsy/seizures	☐ Asthma
☐ High Blood Pressure	☐ Multiple sclerosis	☐ Allergies-list below
☐ Ankle swelling	☐ Head Injury	☐ Latex sensitivity
☐ Anemia	☐ Osteoporosis	☐ Hypothyroid/Hyperthyroid
☐ Low back pain	☐ Headaches	☐ Chronic Fatigue Syndrome
☐ Sacroiliac/Tailbone pain	☐ Fibromyalgia	☐ Diabetes
☐ Alcoholism/Drug problem	☐ Arthritic conditions	☐ Kidney disease
☐ Childhood bladder problems	☐ Stress fracture	☐ Irritable Bowel Syndrome
☐ Depression	☐ Rheumatoid Arthritis	☐ Hepatitis HIV/AIDS
☐ Anorexia/bulimia	☐ Joint Replacement	☐ Sexually transmitted disease
☐ Smoking history	☐ Bone Fracture	☐ Physical or Sexual abuse
☐ Vision/eye problems	☐ Sports Injuries	☐ TMJ/ neck pain
☐ Hearing loss/problems	☐ Emphysema/chronic bronchitis	
☐ Raynaud's (cold hands and feet)		

☐ Other/Describe_____

Surgical History:

☐ back/spine ☐ bladder/prostate ☐ brain ☐ bones/joints
☐ abdominal organs ☐ female organs
☐ Other/describe: _____

_____

Since the onset of your current symptoms have you had:

☐ Fever/Chills	☐ Malaise (Unexplained tiredness)
☐ Unexplained weight changes	☐ Unexplained muscle weakness
☐ Dizziness or fainting	☐ Night pain/sweats
☐ Change in bowel or bladder functions	☐ Numbness / Tingling

☐ Other /describe_____

OB/GYN History *(females only):*

Number of: Pregnancies _____ C-Sections _____ Vaginal deliveries _____
Miscarriage / abortions _____ Difficult deliveries/forceps _____
Episiotomies _____ Vaginal tearing _____ (Grade: ___)

What are you using for birth control? _____

Do you experience: ☐ Regular Periods (☐ heavy ☐ medium ☐ light) ☐ Painful periods
☐ Irregular periods ☐ Menopause
☐ Vaginal dryness ☐ Painful vaginal penetration ☐ Pelvic pain

Do you have a feeling of insides "falling out" / prolapse or pelvic heaviness/pressure?
☐ With standing (after how long? _____) ☐ With exertion/straining ☐ With period
How often? ___Times per month ☐ Never

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Bladder / Bowel Problems: check all that apply

☐ Trouble initiating urine stream
☐ Urinary intermittent /slow stream
☐ Trouble emptying bladder
☐ Difficulty stopping the urine stream
☐ Urinary urgency or frequency
☐ Straining or pushing to empty bladder
☐ Dribbling after urination
☐ Constant urine leakage
☐ Other/describe _____

☐ Blood in urine
☐ Painful urination
☐ Trouble feeling bladder urge/fullness
☐ Current laxative use
☐ Trouble feeling bowel/urge/fullness
☐ Constipation/straining
☐ Trouble holding back gas/feces
☐ Recurrent bladder infections

Bladder Habits:

Frequency of urination: during awake hours: ____ during sleeping hours: _____
How long can you delay a normal urge to urinate? ____ minutes _____hours ☐ not at all
The usual amount of urine passed is: ☐ small ☐ medium ☐ large
Frequency of bladder leakage:
____ times per ☐ day ☐ week ☐ month ☐only with exertion/cough ☐ none
Amount of bladder leakage:
☐ A few drops ☐ wets underwear ☐ wets outwear ☐wets the floor ☐ none

Bowel Habits:

Frequency of bowel movements: _____ per day ____per week ____ per month
How long can you delay a bowel movement before you have to go to the toilet?
_____Minutes ___hours ☐ not at all.
How do you manage constipation? _____
Frequency of bowel leakage:
____ times per ☐ day ☐ week ☐ month ☐only with exertion/cough ☐ none
Amount of bladder bowel leakage:
☐ Stool stain/smear in underwear ☐ small amount in underwear ☐complete emptying
☐ none

What form of protection do you wear? (Please mark only one)
☐ Minimal protection (Tissue paper/paper towel/pantishields)
☐ Moderate protection (absorbent product, maxipad)
☐ Maximum protection (Specialty product/diaper)
☐ None
☐ Other _____
On average, how many pad/protection changes are required in 24 hours? _____# of changes

Do your symptoms change with urinating or having a BM? ☐ better ☐ worse ☐ no change

OTHER General Information you'd like to share:

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamins and diet supplements, and any medications you take on occasion.

Medication	Purpose	Dosage	Frequency	How taken	Initial

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