Therapeutic Evolution PT

Name _____ Date of Birth _____

Address _____

Home/Cell number _____ E-Mail _____

Referring MD _____ MD phone number _____

What is your present complaint? _____

How long have you had this current complaint? _____

List your past surgeries, injuries or major medical problems: _____

_____

Are you currently being seen for any other medical problems? If so, what are they? _____

_____

What have you tried to treat this problem before? Was it effective? _____

_____

What do you do that increases your complaint? _____

What do you do that decreases your complaint? _____

Have you had any special tests? (cystoscopy, MRI, CT scan etc.) _____

Any history of pregnancy? _____ How many? _____ Vaginal or C-section? _____

Vacuum birth/forceps? _____ Episiotomy? _____ Epidural? _____

How old were you when you started to menstruate? _____

Are/were your cycles regular? _____ Painful? _____

How old were you when you first became sexually active? _____ Was it painful?_____

Any history of abuse? _____

Any history of falls on the pelvis or tailbone? _____

Bladder symptoms:

Do you lose urine when you: cough/sneeze/laugh Y N Lift/exercise/jump Y N

On the way to the restroom Y N Hear running water Y N

Do you wear leakage protection? _____ Liner/Mini pad or adult pad? _____

How many do you use during a typical day? _____

Have a strong urge to urinate? _____ Do you wet the bed? _____

Do you have burning pain with urination? _____ _____

Have difficulty starting a stream of urine? _____

Strain to empty your bladder? _____

Feel unable to empty your bladder? _____

Have pain with a full bladder? _____ Have urgency to urinate? _____

Urinate more than 7 times per day? _____ How many during the day? _____ Night? _____

How many glasses of fluids to you intake per day? Water _____ Caffeine _____

Alcohol _____ Other _____

Bowel Symptoms:

Do you strain to have a bowel movement? Y N Leak or stain feces? Y N

Include fiber in your diet? Y N Have diarrhea often? Y N

Take laxatives or use enemas regularly? Y N Leak gas by accident? Y N

Have pain with bowel movements? Y N

Have a very strong urge to move your bowels? Y N

How often do you move your bowels? _____ per day, week _____

Most common stool consistency: liquid _____ soft _____ firm _____ pellets _____ other _____

Sexual Symptoms:

Do you have pain with intercourse: Y N Pain after sex? Y N

Do you tolerate manual sex? Y N Oral sex? Y N

Do you need lubricant: Y N Are you able to climax? Y N

Thank you for filling out this questionnaire!