CENTERED

Physical Therapy & Wellness

Patient Symptom History

Name: _____Sex:_____Age:_____Date:_____

1. Describe your current problem(s):_____
   _____
1. Physician Diagnosis/Thoughts: _____
2. When did your symptoms first begin? _____
3. Was this problem brought on by an incident? **YES/NO**
4. Please Describe:_____
   _____
5. Are you sexually active? Yes/No, if No, why not?_____
   _____

6. How has your life changed due to your symptoms (please explain)?
   - Social Activities:_____
   - Diet/Fluid Intake:_____
   - Physical Activity: _____
   - Work: _____
   - Other:_____

OB/GYN History:

Y/N Childbirth Vaginal Delivery #___
Y/N Episiotomy #___
Y/N C-Section #___
Y/N Difficult Delivery #___
Y/N Prolapse or Organ Falling Out
Y/N Vaginal Dryness
Y/N Painful Periods
Y/N Menopause- when? _____
Y/N Painful Vaginal Penetration
Y/N Pelvic Pain
Other/Describe:_____

Medications, Over the Counter, Vitamins etc. (include start date and reason for taking)

_____
_____
_____

Pelvic Pain Questionnaire

Are you in Pain ( )Yes/( )No, If Yes please fill in the blanks if no skip to next section

5. Is this pain getting **WORSE/BETTER/SAME**? Describe: _____
_____
6. If you are in pain what would you rate it on a scale from 0-10 (10 being the worse):_____
7. Describe your pain (throbbing, burning, stinging etc.)_____
_____

8. What type of treatment have you received or given yourself? _____
_____
9. Check what aggravates your symptoms (check all that apply:

___Sitting greater than _____mins
___Walking greater than ____mins
___Standing greater than ____mins
___Changing positions
___ Light activity or housework
___Vigorous activity/exercise
___Sexual activity
___With cough/sneeze/straining
___With laughing/yelling
___With cold weather
___With lifting/bending
___With triggers (ex: hearing running water)
___With anxiety or nervousness
___Nothing affects the problem
___Other, Please describe:
_____
_____
_____

10. What relieves your symptoms? _____
_____
11. Are you sexually active? Yes/No, if No, why not?_____
_____

12. How has your life changed due to your symptoms (please explain)?
    - Social Activities:_____
    - Diet/Fluid Intake:_____
    - Physical Activity: _____
    - Work: _____
    - Other:_____

Bladder Symptom Questionnaire

( )Yes/( )No: If Yes please answer the following. If No leave blank and skip to next section.

Bladder/ Bowel Habits

Y/N Trouble initiating urine stream
Y/N Urinary intermittent/ slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining/pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Blood in urine

Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infection

Other/Describe:_____

1. Frequency of urination: awake hours____times per day, sleep hours____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all
3. The usual amount of urine passed is: _____small _____medium _____large
4. Frequency of bowel movements_____times per day, _____times per week, or _____
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all
6. If constipation is present describe management techniques_____
7. Average fluid intake (1 glass is 8 oz or one cup) _____glasses per day
   - Of this fluid how many glasses are caffeinated? _____glasses per day
8. Rate a feeling of organ “falling out”/prolapse or pelvic heaviness/pressure:
   ___None present
   ___Times per month: Specify is related to activity or your period _____
   ___With standing for _____minutes or _____ hours
   ___With exertion or straining
   ___Other: Explain _____

Skip following questions if no leakage/incontinence

9a. Bladder leakage-number of episodes
___No leakage
___Times per day
___Times per week
___Times per month
___Only with physical exertion/coughing

9b. Bowel leakage-number of episodes
___No leakage
___Times per day
___Times per week
___Times per month
___Only with exertion/strong urge

10a. On average, how much urine do you leak?
___No leakage
___Just a few drops
___Wets underwear
___Wets outerwear
___Wets the floor

10b. How much stool do you lose?
___No leakage
___Stool staining
___Small amount in underwear

___Complete emptying

11. What form of protection do you wear? (Please complete only one)
    ___None
    ___Minimal protection (Tissue paper/paper towel/pantyshields)
    ___Moderate protection (absorbent product, maxipad)
    ___Maximum protection (Specialty product/diaper)
    ___Other _____
    On average, how many pad/protection changes are required in 24 hours? ___# of pads

12. After starting to urinate, can you completely stop the urine flow? (circle one)
    Can stop completely
    Can maintain a deflection of the stream
    Can partially deflect the urine stream
    Unable to deflect or slow the stream

13. Do you have trouble initiating a urine stream? YES/NO
14. Do you have pain with urination? Yes/No, Describe:_____
    _____

15. What are your goals for treatment? _____
_____