In Touch Physical Therapy

Your pain stops here

Name:_____ Age: _____ Sex: _____ Today's Date:_____

Email address: _____ How did you hear about us? _____

Do you want to be subscribed to our E-newsletters? Yes or No

Emergency Contact:_____Phone Number:_____

Diagnosis:_____ Referring Physician:_____

What is your problem and when did it begin? _____

_____

Goals For Pelvic Floor Rehab: _____

Symptoms/Pain Location(s): _____

Please rate your symptoms at **WORST:** (0=no pain, 10=worst pain)

☺ 0---1---2---3---4---5---6---7---8---9---10 ☹

Please rate your pain **TODAY:**

☺ 0---1---2---3---4---5---6---7---8---9---10 ☹

Please rate your pain at **BEST:**

☺ 0---1---2---3---4---5---6---7---8---9---10 ☹

Please circle the best descriptors of your symptoms:

Throbbing Sharp Dull/Aching Pounding Sore

Nauseating Pulsing Burning Dull

Miserable Beating Hot Heavy Numbness/Tingling

Other: _____

Women:

Childbirth History:

Number of vaginal births: _____ C-sections: _____

Did you have any prolonged pushing? Yes / No

Painful episiotomy? Yes / No

Forceps delivery? Yes / No

Hysterectomy? Yes / No

Other Gyn surgeries? _____

Do you have pain with sexual intercourse? Yes / No

Explain:_____

_____

Men:

Do you have a prostate condition? Yes / No

Explain:_____

_____

If so, what treatment have you had? _____

_____

_____

Do you have problems with sexual function? Yes / No

Explain:_____

_____

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Bowel Habits:

How often do you have a BM? _____

What is the volume of bowel moved? Small / Medium / Large amounts

What is the consistency of your usual stool? Pellet / firm / soft / liquid / other_____

How strong is your need to defecate? Urgent / strong / average / minimal / none

Can you suppress the urge to defecate? Yes / No For how long? _____

Can you distinguish between gas, liquid, and solid in the rectum? Yes / No

Do you pass ever mucus or blood from the rectum? Yes / No

Are you ever constipated? Yes / No If yes, how often? _____

Do you strain to move your bowels? Yes / No

Do you use enemas, suppositories, laxatives, or a stool softener? Yes / No If yes, how often? _____

Do you ever have rectal pain, pressure, or burning? If yes, please explain: _____

_____

List any other substances you use to firm or soften the stool: _____

_____

Do you ever have uncontrolled loss of stool or soiling? Yes / No If yes, how often? _____

If you have loss of stool, is the stool: uncontrolled solid / soft / liquid

Is loss of stool associated with an activity (lifting, coughing, running) or a food? _____

Number of pads or underwear changes (due to loss of stool)? _____

What sources of dietary fiber do you ingest? _____

Are there any foods that increase or decrease your symptoms? _____

Do you have any food allergies? (milk, spicy foods) _____

Recent remodeling of bathroom/move? _____

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Urinary Habits:

How often do urinate during the day time? _____

How often do you get up at night to urinate? _____

Do you have urinary leakage (incontinence)? Yes / No How often do you have urine loss?_____
When did it begin? _____ Worsen? _____

Is your loss of urine associated with…

- coughing, laughing, sneezing, exercise, running or jumping? Yes / No _____

- With strong urge to urinate? Yes / No _____

- On the way to the toilet or just as you get there? Yes / No _____

Do you wear an absorbent product? Yes / No *If yes*, what kind/size? _____

Number of pads/diapers/or clothing changes per day: _____

Do you experience the urge to urinate with the sound of running water? Yes / No

Do you have to rush to get to the toilet "in time"? Yes / No

Do you have difficulty initiating the flow of urine? Yes / No

Do you have difficulty maintaining the flow of urine? Yes / No

Do you feel that you completely empty your bladder? Yes / No

Do you dribble after emptying? Yes / No

Do you ever have blood in your urine? Yes / No

Do you ever have pain when you urinate? Yes / No

What treatment(s) have you had for urinary problems? exercises / medications / surgery / other_____

_____

Do you have abdominal pain? Yes / No If yes Where? _____ How often? _____
Describe the quality of pain: constant / crampy / burning / vague / other _____

What makes your abdominal pain worse? _____ Better? _____

Do you ever have nausea or vomiting / belching / reflux / trouble swallowing / indigestion / feeling full early when eating / loss of appetite / excessive passing of gas from the rectum / abdominal bloating or weight loss? (please circle all that apply) Explain: _____