

CENTER FOR REHABILITATION AND WELLNESS

Patient History Form

Patient Name:	Age:	Date:
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1. Describe your current problem?

2. When did your problem first begin? _____ months ago or _____ years ago.

3. Was your first episode of the problem related to a specific incident? Yes / No

Please describe and specify date:

4. Since that time is it staying the:	Same	Getting worse	Getting better
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Why or how?

5. If pain is present rate pain on a 0-10 scale 10 being the worst. ____/10

Describe the nature and location of the pain (i.e. constant burning, intermittent ache):

6. Describe previous treatment / exercises (more specifically, have you ever been taught how to perform Kegel exercises?)

If yes, how often do you perform the exercises?

7. What relieves your symptoms?

8. How has your lifestyle / quality of life been altered / changed because of this problem?

9. Rate the severity of this problem from 0-10 with 0 being no problem & 10 being the worst. ____

10. What are your treatment goals / concerns?

11. Since the onset of your current symptoms have you had:

Yes / No	Fever / Chills	Yes / No	Malaize (unexplained tiredness)
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Yes / No	Unexplained weight change	Yes / No	Unexplained muscle weakness
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Yes / No	Dizziness or fainting	Yes / No	Night pain / sweats
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Yes / No	Change in bowel / bladder functions	Yes / No	Numbness / Tingling
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Yes / No	Other / describe:
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9. Mark any feeling of organ "falling out" / prolapse or pelvic heaviness / pressure.			
<input type="checkbox"/> None present			
<input type="checkbox"/> Times per month (specify if related to activity or your period)			
<input type="checkbox"/> With standing for _____ minutes or _____ hours.			
<input type="checkbox"/> With exertion or straining			
<input type="checkbox"/> Other:			
Skip questions if no leakage / incontinence			
10a. Bladder leakage – number of episodes		10b. Bowel leakage – number of episodes	
<input type="checkbox"/> No leakage		<input type="checkbox"/> No leakage	
<input type="checkbox"/> Times per day		<input type="checkbox"/> Times per day	
<input type="checkbox"/> Times per week		<input type="checkbox"/> Times per week	
<input type="checkbox"/> Times per month		<input type="checkbox"/> Times per month	
<input type="checkbox"/> Only with physical exertion / cough		<input type="checkbox"/> Only with exertion / strong urge	
11a. On average, how much urine do you leak?		11b. How much stool do you lose?	
<input type="checkbox"/> No leakage		<input type="checkbox"/> No leakage	
<input type="checkbox"/> Just a few drops		<input type="checkbox"/> Stool staining	
<input type="checkbox"/> Wets underwear		<input type="checkbox"/> Small amount in underwear	
<input type="checkbox"/> Wets outerwear		<input type="checkbox"/> Complete emptying	
<input type="checkbox"/> Wets the floor			
12. What form of protection do you wear? (Please complete only one)			
<input type="checkbox"/> None			
<input type="checkbox"/> Minimal protection (Tissue paper / paper towel / pantishields)			
<input type="checkbox"/> Moderate protection (specialty product / diaper)			
<input type="checkbox"/> Maximum protection (specialty product / diaper)			
<input type="checkbox"/> Other:			
On average, how many pad / protection changes are required in 24 hours?			# of pads
13. After starting to urinate, can you completely stop the urine flow? (please check or circle)			
Can stop completely	Can maintain a deflection of the stream	Can partially deflect the urine stream	Unable to deflect or slow the stream

Health History:	Date of last pelvic exam:	Tests performed:	
General Health:	Excellent Good Average Fair Poor		
Occupation:	Hours / week:	On disability or leave?	Activity restrictions?
Mental Health:	Current level of stress: High __ Med __ Low __ Current psych therapy? Y/N		
Activity / Exercise:	None 1-2 days/week 3-4 days/week 5+ days/week		
Describe:			
Have you ever had any of the following conditions or diagnoses? Circle all that apply			
Cancer	Stroke	Rheumatoid arthritis	Irritable bowel syndrome
Heart problems	Epilepsy/seizures	Joint replacement	Hepatitis HIV/AIDS
High blood pressure	Multiple sclerosis	Allergies – list below	Sexually transmitted disease
Low back pain	Osteoporosis	Latex sensitivity	Physical or Sexual abuse
Childhood bladder problems	Chronic fatigue syndrome	Headaches	Raynaud's (cold hands and feet)
Depression	Fibromyalgia	Diabetes	Pelvic Pain
Smoking history	Arthritic conditions	Kidney disease	
Other / describe:			
Surgical / Procedure History: Please list:			
Ob/Gyn History (females only): Please list:			
Yes / No	Childbirth vaginal deliveries # ____	Yes / No	Vaginal dryness
Yes / No	Episiotomy # ____	Yes / No	Painful periods
Yes / No	C-Section # ____	Yes / No	Menopause – when? ____
Yes / No	Difficult childbirth # ____	Yes / No	Painful vaginal penetration
Yes / No	Prolapse or organ falling out	Yes / No	Pelvic Pain
Yes / No	Other / describe:		
Medications – pills, injection, patch, etc. (please list):			