PALMER PHYSICAL THERAPY for WOMEN

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INCONTINENCE/PELVIC PAIN PATIENT FORM

Date: _____/_____/_____

Name: _____Age: _____ Height: _____ Weight: _____

Referring Physician: _____ Next Appt: _____

Occupation/Type of Work: _____ Hours per week: _____

How did you find out about us? ☐ TV ☐ Radio ☐ Billboard ☐ Website ☐ Doctor ☐Other _____

Medical History:☐ Hysterectomy; (☐ Abdominal or ☐ Vaginal; Are Ovaries intact? ☐Yes ☐ No)
Onset of Menopause _____ Are you being treated with Hormone Replacement Therapy? ☐Yes ☐No ☐ Cancer
☐ Pacemaker ☐ Bowel Repair ☐ Back/Neck Surgery ☐Bladder Repair ☐ Heart Disease ☐ Kidney Problems
☐ Diabetes ☐Recurrent Bladder/Yeast Infections ☐Osteoporosis/Osteopenia ☐ Recent unexplained weight loss
☐ Lung/Breathing Problems ☐ Arthritis ☐ Hypertension ☐Current treatment that suppresses immune function
☐ Stroke/CVA ☐ Fractures ☐ Metal Implants ☐ Recent accident (if yes, explain) _____
☐ Depression ☐Other: _____
Have you used a tobacco product in the past year? ☐Yes☐ No

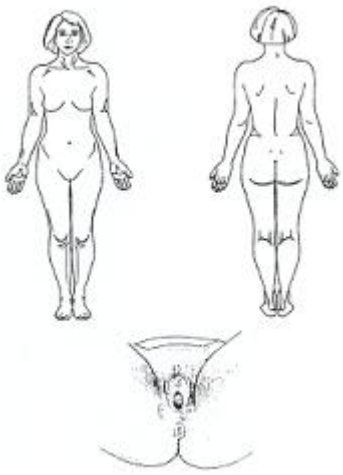
Do you have a fear of falling? ☐Yes ☐No Have you fallen in the past year? ☐Yes ☐No (If yes, how many falls?___)
Were you injured in a fall in the past year? ☐Yes ☐No (If yes, explain_____)

Have you ever had a Sexually Transmitted Disease? ☐Yes ☐No If yes _____
Please list any Allergies: _____
Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____
Has your physician limited any activity? ☐ Yes ☐ No If so, please explain _____
_____

Current Medication list: Please bring a copy with you to your appointment

When did the problem(s) begin? _____
Are your symptoms getting worse? ☐ Yes ☐ No
Prior Treatment (No/Yes; If yes, explain):_____

Mark Area(s) of Pain



Where do you have pain? ☐ low back ☐ neck ☐ abdomen/pelvis
☐ vagina ☐ rectum ☐ headache/migraines ☐ other: _____

Rate your level of pain for your primary complaint from 0 to 10:
0= no pain, 1= very mild, 2= discomforting, 3= tolerable, 4= distressing, 5= very distressing,
6= intense, 7= very intense, 8= utterly horrible, 9= excruciating, 10= will go unconscious shortly
_____at worst _____at best _____on average _____current

What makes your pain worse? _____

What makes your pain better? _____

Do you have pain, numbness or tingling in your:
Legs/feet ☐ Yes ☐ No Arms/hands ☐ Yes ☐ No

Do you participate in sports, hobbies, exercise programs, or activities? _____
_____

(please complete questions other side)

Do you leak urine? ☐ Yes ☐ No How long have you had a problem with leaking urine? _____

How often do you empty your bladder?
☐ every 4 hrs. ☐ every 3 hrs. ☐ every 2 hrs. ☐ 1 hr. ☐ every 30 min. ☐ don't know

How often do you empty your bladder at night?
☐ never or rarely ☐ 1 time/night ☐ 2 times/night ☐ 3 times/night ☐ 4 times/night ☐ 5 times/night or more

How often do you leak urine? ☐ less than 1 per week ☐ more than 1 per week (#___ per week) ☐ 1 per day
☐ more than 1 per day (#___ per day) ☐ continual leaking
When does leaking occur? ☐ mainly during day ☐ mainly during night ☐ day and night

When you leak, how much do you leak? ☐ just a few drops ☐ less than a cup ☐ more than a cup ☐ don't know
Are you aware that you had leaked? ☐ Yes ☐ No

Do any of the following cause you to leak urine?
☐ exercise ☐ laughing ☐ coughing ☐ sneezing ☐ walking ☐ running water ☐ lifting/straining
☐ strong urge to urinate ☐ getting to toilet/removing clothes

When you urinate, do you have:
☐ burning ☐ discomfort or pain ☐ blood in urine ☐ dribbling after ☐ problems with starting the stream

What type of protective devices do you use?
☐ pantyliner ☐ minipad ☐ maxipad ☐ incontinence brief Number of pads/briefs used per day? _____

How many cups of fluid do you drink per day? _____ Of those, how many are caffeinated and/or carbonated? _____
Do you restrict fluids because of your incontinence? ☐ Yes ☐ No

Do you ever experience bowel accidents? ☐ Yes ☐ No If yes, # of times per day _____ per week _____
Are the accidents only with loose stool? ☐ Yes ☐ No

Do you ever experience fecal staining? ☐ Yes ☐ No Any difficulty holding gas? ☐Yes ☐No
Do you require multiple attempts for cleaning after a bowel movement? ☐ Yes ☐ No

Usual frequency of bowel movements _____ Any recent change? _____
Are you ever constipated? ☐ Yes ☐ No Do you use laxatives? ☐ Yes ☐ No

Consistency of stool _____ Do you have pain before or after bowel movement? ☐ Yes ☐ No
Do you feel an urge to have a bowel movement? ☐ Yes ☐ No Do you feel empty after? ☐ Yes ☐ No
Do you have to manually assist to have a bowel movement? ☐ Yes ☐ No

Number of pregnancies _____ Number of vaginal deliveries _____ Number of C-sections _____

Do you ever have painful intercourse? ☐ Yes ☐ No If yes, check when: ☐ Initial entry ☐ Deep penetration
Rate your pain (0 to 10) _____ Does pain linger? ☐ Yes ☐ No Is this a new problem? ☐ Yes ☐ No

Do you experience vaginal heaviness or pressure? ☐ Yes ☐ No

What do you expect to accomplish with physical therapy? _____

_____

Briefly describe any additional concerns: _____

_____

_____