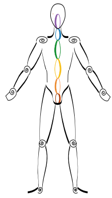

Orthopedic & TMJ Physical Therapy Center
Confidential Health Questionnaire
Bowel Disorders

Name:______________________________ D.O.B.: ___________________________

Date: ___________________________ Occupation: ________________________

General Health Questions

1. Have you ever had any of the following conditions or problems? Be descriptive when appropriate.

- ❍ Anemia
- ❍ Arthritis
- ❍ Asthma
- ❍ Cataracts
- ❍ Cancer
- ❍ Chest Pains
- ❍ Circulatory problems
- ❍ Constipation/Impaction
- ❍ Convulsions
- ❍ Diabetes
- ❍ Digestive problems
- ❍ Dizziness
- ❍ Eliminatory problems
- ❍ Falls
- ❍ Fractures
- ❍ Head aches
- ❍ Head Injuries
- ❍ Heart condition
- ❍ Hemophilia
- ❍ Hemorrhoids
- ❍ High/low blood pressure
- ❍ HIV, AIDS
- ❍ Irritable Bowel
- ❍ Kidney/Bladder Stones
- ❍ Migraines
- ❍ Mitral valve prolapse
- ❍ Multiple Sclerosis
- ❍ Osteoporosis
- ❍ Osteomyelitis
- ❍ Pacemaker
- ❍ Parkinson's Disease
- ❍ Polyps
- ❍ Phlebitis
- ❍ Pregnancy Trauma
- ❍ Renal Diesase
- ❍ Respiratory problems
- ❍ Seizures
- ❍ Skin Conditions
- ❍ Thyroid problems
- ❍ Vascular Disease
- ❍ Musculoskeletal
  - ❍ TMJ
  - ❍ Shoulders
  - ❍ Neck
  - ❍ Hips
  - ❍ Back
  - ❍ Knees
  - ❍ Feet

Other ______________________
____

____
____

2. When was your last Medical exam? ❍ Within last month ❍ Within last 6 months ❍ More than 6 mo.
3. Have you ever been diagnosed for cancer, a tumor, or noticed any lumps or swellings? ❍ Yes ❍ No
4. Do you Smoke? ❍ Yes ❍ No
5. Do you drink alcohol (if so list # per week)? ❍ No. ____Beer. ____Wine. ____Spirits.
6. Education ❍ High School ❍ College ❍ Graduate ❍ Professional Training
7. Are you currently under the care of a physician/chiropractor/therapist/acupuncturist, counselor,… etc? Provider's Name & Specialty
   ____
   ____
   ____
8. Have you ever been treated for any of the following: ❍ Anxiety ❍ Depression ❍ Nervous Problems ❍ Drug Addiction ❍ Alcoholism ❍ None of the above
9. Do you experience:
   - ❍ Numbness/tingling/weakness in anywhere in your body
   - ❍ Pain or discomfort with sexual activity
   - ❍ Clicking, popping, or pain in your jaw

❍ None of the above

10. Please list any past injuries and/or accidents (include dates if possible):
____
____
____
____

11. Please list in any past injuries, including falling on your coccyx/tailbone, that resulted in pain or limitation in sitting (including dates if possible): ______________________________
____
____

12. Hours of sitting per day (computer + driving) ______________________________

13. Have you ever seen a physical therapist before? ❍Yes ❍No

14. Please list all medications you are currently taking (prescription and over the counter)?

Name & Dosage	Reason for taking
____________	______________________________
____________	______________________________
____________	______________________________
____________	______________________________

15. **Daily Fluid Intake & Diet:**

Indicate what amount you drink of the following in a typical day. ____Water (8oz.) ____Juice (8oz.) ____ Coffee (cups) ____ Tea (cups) ____ Soda (8oz.) Do you restrict fluids❍Yes ❍No

Please describe your diet.______________________________
____
____

Allergies: medication, food or other ______________________________
____
____

16. **Bowel Habits:**

How often do you have a bowel movement? _______________
Are you ever constipated?
How do you resolve this? ______________________________
Do you experience diarrhea? ❍Yes ❍No
Do you use laxatives? ❍Yes ❍No How often/week ________
Do you use enemas? ❍Yes ❍No How often/week ________
Do you leak fecal matter or stain underwear? ❍Yes ❍No
Do you include fiber in your diet (fruit, vegetables, bran, etc.)? ❍Yes ❍No

17. **Previous Treatment for Incontinence**

Have you done exercises (e.g. Kegels) to control urine loss? ❍Yes ❍No
Is so, were they helpful? ❍Yes ❍No
Has your doctor prescribed any medication to treat urine loss? ❍Yes ❍No
Have you had any surgical procedures to treat urine loss? ❍Yes ❍No

18. **Currently**

Do you experience a loss of stool… with coughing, laughing, sneezing? ❍Always ❍Sometimes ❍Never
with lifting heavy objects? ❍Always ❍Sometimes ❍Never
with exercising running, etc? ❍Always ❍Sometimes ❍Never
when you have a strong urge to defecate? ❍Always ❍Sometimes ❍Never
on the way to the toilet? ❍Always ❍Sometimes ❍Never
just as getting to toilet/removing clothes? ❍Always ❍Sometimes ❍Never

Do you lose stool….
By continuous oozing ❍Always ❍Sometimes ❍Never
In small amounts ❍Always ❍Sometimes ❍Never
In moderate amounts ❍Always ❍Sometimes ❍Never
In sudden large amounts ❍Always ❍Sometimes ❍Never
Other, specify ___________________________________

Before an accident occurs do you have an urge sensation to pass your bowel? ❍Yes ❍No ❍Unsure

What is the consistency of stool loss:
Formed ❍Always ❍Sometimes ❍Never
Hard ❍Always ❍Sometimes ❍Never
Liquid ❍Always ❍Sometimes ❍Never
Stringy ❍Always ❍Sometimes ❍Never
Other, specify ______________________________

Are your episodes of stool loss
During the day ❍Always ❍Sometimes ❍Never
At night ❍Always ❍Sometimes ❍Never
Morning ❍Always ❍Sometimes ❍Never
Afternoon ❍Always ❍Sometimes ❍Never
Daily ❍Always ❍Sometimes ❍Never
Weekly ❍Always ❍Sometimes ❍Never

Is there a relationship between accidents and:
Meals ❍Always ❍Sometimes ❍Never
Activity ❍Always ❍Sometimes ❍Never
Flatulence/gas ❍Always ❍Sometimes ❍Never
Certain foods ❍Always ❍Sometimes ❍Never
If so which type of foods: ________________________

Did your problem begin after any of the following:
Back surgery/trauma ❍Yes ❍No
Brain Surgery ❍Yes ❍No
Bowel Surgery ❍Yes ❍No
Stroke ❍Yes ❍No
Rectal Surgery ❍Yes ❍No
Cancer diagnosis ❍Yes ❍No
Radiation Therapy ❍Yes ❍No
Vaginal Delivery ❍Yes ❍No
Episiotomy ❍Yes ❍No
Other, specify _________________________________

Do you wear a pad? ❍Always ❍Sometimes ❍Never
and when changing a pad are the pads…
slightly soiled ❍Always ❍Sometimes ❍Never
moderately soiled ❍Always ❍Sometimes ❍Never
largely soiled ❍Always ❍Sometimes ❍Never

Do you… have to strain to empty your colon? ❍Always ❍Sometimes ❍Never
dribble stool after your bowel movement? ❍Always ❍Sometimes ❍Never
recognize leakage as it occurs? ❍Always ❍Sometimes ❍Never
have pain during a bowel movement? ❍Always ❍Sometimes ❍Never
how long after___________________________

Do you… have difficulty initiating a bowel movement? ❍Yes ❍No ❍Unsure
have difficulty stopping a bowel movement? ❍Yes ❍No ❍Unsure
have blood in your stool? ❍Yes ❍No ❍Unsure

19. **Voiding Patterns:**

Voiding frequency: # of times/day ______ # of times/night ______
leakage episodes/day ______ # leakage episodes/night ______
Amount of urine when voiding ___ large ___ small ___ few drops

20. **Protective Devices:**

What type of protective devices do you use? (Check all that apply)
❍ pantyliner ❍ incontinence pad ❍ sanitary pad (mini) ❍ sanitary pad (maxi)

# of pads used each day? _____
Do you soak the pad full? ❍Yes ❍No
Do you change the pad each time it's wet? ❍Yes ❍No

21. Mobility/Self-Care:

Do you......
use a cane? ❍Yes ❍No
use a walker? ❍Yes ❍No
lean on furniture for balance? ❍Yes ❍No

Do you have difficulty.....
with getting on/off the toilet? ❍Yes ❍No
getting clothes on/off? ❍Yes ❍No
with toilet hygiene? ❍Yes ❍No

22. **Gynecological History (if applicapble) :**

# of pregnancies: _____ #of vaginal deliveries: _____ length of time pushing: __________
# of episiotomies: _____ # of C-sections: ____
Do you have a painful episiotomy scar ? ❍Yes ❍No
Do you have a history of urinary tract infections ? ❍Yes ❍No
Do you have a history of urine loss as a child ? ❍Yes ❍No
as an adolescent ? ❍Yes ❍No
after childbirth ? ❍Yes ❍No

If applicable, when was your menopause onset? _________________

Have you been on Hormone Replacement Therapy? ❍Yes ❍No Currently? Y N
Dosage: Estrogen: __________ *Type:* Pills ______
Progesterone: __________ Patch ______
Cream ______

23. **Surgical History:** (please provide dates of all that apply to you)

_____back/neck surgery
_____kidney surgery
_____bladder repair
_____hysterectomy
_____abdominal
_____vaginal
_____ovaries removed
_____appendectomy
_____hernias
_____gall bladder surgery
_____prostate removal
_____rectal

24. **Psychosocial Status:**

Please list exercise, sports, hobbies or musical instruments ______________________________
____
____

Please describe your sleeping habits (Snoring, # of hours, position, # of pillows) .___________________
____

Are you sexually active? ____
Is there a history of sexually transmitted diseases? ______________________________
Living arrangements: Do you live alone? ❍Yes ❍No
Have you had to restrict your activities due to incontinence or pain? ❍Yes ❍No
Have you had changes in intimate relationships/sexual functioning due to urinary incontinence or pain? ❍Yes ❍No

25. In your own words please describe your problem: ____
____
____
____
____
____

26. **Life Impairment:** What are your feelings about your problem on a scale of 1 to 10?

No Impairment 0 1 2 3 4 5 6 7 8 9 10 Severe Impairment

27. How did you hear about our clinic?____

THANK YOU