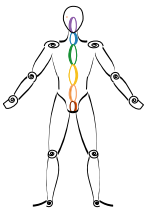

Orthopedic & TMJ Physical Therapy Center
Confidential Health Questionnaire

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
- ❍ Osteoporosis
- ❍ 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. Hours of sitting per day (computer + driving) _____

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

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

13. Check all that apply: ❍ Face/brow lift ❍ Cheek/chin implants ❍ Breast augmentation/reduction
14. Have you ever seen a physical therapist before? ❍Yes ❍No

15. Please list all medications you are currently taking (prescription and over the counter)?
Name & Dosage Reason for taking
_____ _____
_____ _____
_____ _____

16. **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 _____
_____

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 urine…	with coughing, laughing, sneezing?	❍Yes ❍No
	with lifting heavy objects?	❍Yes ❍No
	with exercising running, etc?	❍Yes ❍No
	when you have a strong urge to urinate?	❍Yes ❍No
	on the way to the toilet?	❍Yes ❍No
	with “key in lock?	❍Yes ❍No
	just as getting to toilet/removing clothes?	❍Yes ❍No
Do you	experience an urge to urinate when you hear running water?	❍Yes ❍No ❍Unsure
	have difficulty initiating a urine stream?	❍Yes ❍No ❍Unsure
	have difficulty stopping your stream?	❍Yes ❍No ❍Unsure
	have pain with urination?	❍Yes ❍No ❍Unsure
	have blood in your urine?	❍Yes ❍No ❍Unsure
	have to strain to empty your bladder?	❍Yes ❍No ❍Unsure
	dribble urine when urinating?	❍Yes ❍No ❍Unsure
	dribble urine after urinating?	❍Yes ❍No ❍Unsure

recognize leakage as it occurs?	❍Yes ❍No ❍Unsure
With an uncontrolled loss of urine… is it usually a large amount?	❍Yes ❍No ❍Unsure
Is it usually a small amount?	❍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. **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

23. **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 _____

24. **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

25. **Psychosocial Status:**

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
Please list exercise, sports, hobbies or musical instruments _____
_____
_____
Please describe your sleeping habits (Snoring, # of hours, position, # of pillows) ._____
_____

26. In your own words please describe your problem: _____
_____
_____
_____
_____
_____

27. **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

28. How did you hear about our clinic?_____

THANK YOU