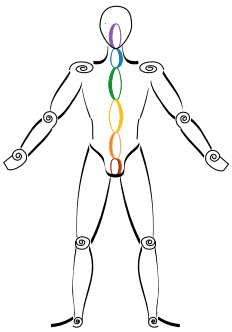

Orthopedic and TMJ Physical Therapy Center
Confidential Health Questionnaire
Pelvic Pain

Name:_____ D.O.B.: _____ Age: _____

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/Vertigo
- ❍ 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/Delivery/Trauma
- ❍ Renal Disease
- ❍ Respiratory problems
- ❍ Seizures
- ❍ Skin Conditions _____
- ❍ Sleep Apnea
- ❍ Stress
- ❍ Thyroid problems
- ❍ Vascular Disease
- ❍ Musculoskeletal
  - ❍ TMJ ❍ Shoulders
  - ❍ Neck ❍ Hips
  - ❍ Back ❍ Knees
  - ❍ Feet

Other : _____
_____
_____
_____
_____

_____
_____

2. Hours of sitting per day (computer + driving) _____
3. When was your last Medical exam? ❍Within last month ❍Within last 6 months ❍ More than 6 mo.
4. Have you ever been diagnosed for cancer, a tumor, or noticed any lumps or swellings? ❍Yes ❍No
5. Do you Smoke? ❍Yes ❍No
6. Do you drink alcohol (if so list # per week)? ❍ No. ____Beer. ____Wine. ____Spirits.
7. Education ❍ High School ❍College ❍Graduate ❍Professional Training
8. Are you currently under the care of a physician/chiropractor/therapist/acupuncturist, counselor,… etc? Provider's Name & Specialty

_____
_____
_____

9. Have you ever been treated for any of the following: ❍ Anxiety ❍ Depression ❍ Nervous Problems
   ❍ Drug Addiction ❍ Alcoholism ❍None of the above
10. Do you experience:
    - ❍ Numbness/tingling/weakness in anywhere in your body
    - ❍ Urinary leaking with exercise, laughing, coughing, or on the way to the bathroom
    - ❍ Clicking, popping, or pain in your jaw
    - ❍ None of the above
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.)
    Please describe your diet.
    _____
    _____
    Allergies: medication, food or other _____
    _____
17. **Bowel Habits:**
    How often do you have a bowel movement? _____
    Are you ever constipated? ❍Yes ❍No
    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
18. **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

19. **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

20. **Gynecological History (if applicable) :**

# of pregnancies: _____ Please list year(s) when pregnant :_____
#of vaginal deliveries: _____ length of time pushing: _____
# of episiotomies: _____ Do you have a painful episiotomy scar ? ❍Yes ❍No
# of C-sections: ____ 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 _____

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

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

22. **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) _____
_____
What are your current stress levels: _____Low _____Med _____High

23. In your own words please describe your problem and when it began: _____
_____
_____
_____

24. What is your goal with therapy: _____
_____

25. **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

26. How did you hear about our clinic?_____

Thank you for taking the time to fill out this questionnaire.