Prosser Therapy Services
Prosser Memorial Health

Sticker

Pelvic Rehabilitation Patient History

What brings you to physical therapy today?____
____

When did this problem begin? ___ Months Ago ____ Years Ago

Was this the first episode of this incident? Yes/No
Describe and state the date(s)

Since the first episode has it:
__Stayed the Same __Worsened __ Improved

If you have pain, please rate it on a scale of 0 (no pain) to 10 (worst pain). ______ Describe it (burning, tingling, aching, constant, intermittent)________________________________

Describe previous treatments or exercises you have done for this condition________________________________
____

Please check ALL of the activities that aggravate your symptoms
__ Sitting greater than __ Minutes
__ Standing greater than __ Minutes
__ Walking greater than __ Minutes
__ Changing positions (in sitting to standing)
__ Light Activities (light housework)
__ Vigorous Activities/Exercises (run, lifting, jumping)
__ Sexual Activities
__ With cough/sneeze/strain
__ With laughing/yelling
__ With lifting/bending
__ With cold weather
__ With triggers- running water, key in door
__ With nervousness
__ No activity worsens my symptoms
__Other:____
____

What relieves your symptoms?____
____

How has your lifestyle been affected by this problem? (ie. Work, social, physical activity, diet/fluid)
____
____

Rate the severity of this problem on a scale from 0 (no problem) to 10 (worst problem) ____________________
What are your goals or concerns? ____
____

Since the onset of your symptoms have you had:
Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness/Fainting
Y/N Change in bowel or bladder function
Y/N Unexplained tiredness
Y/N Unexplained muscle weakness
Y/N Night pain or sweats
Y/N Numbness/Tingling
Other:____

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Health History
Date of Last Physical Examination: ___________ Tests Performed: __________________

General Health: Excellent Good Fair Poor
Occupation:________________ Hours/Week:_______ Disability/Leave_________________
Mental Health: Current Stress Level __High ___ Moderate __ Low Current Psych Therapy? Y/N

Activity/Exercise None 1-2x/week 3-4x/week 5+/week
Describe:____

Have you ever had the following conditions or diagnoses? Circle all that apply

Cancer
Heart Problems
High Blood Pressure
Ankle Swelling
Anemia
Low Back Pain
Sacroiliac/Tailbone Pain
Alcoholism/Drug Problem
Childhood Bladder Problem
Depression
Anorexia/bulimia
Smoking History
Vision/eye Problems
Hearing loss/problems

Stoke
Epilepsy/seizure
Multiple Sclerosis
Head Injury
Osteoporosis
Chronic Fatigue Syndrome
Fibromyalgia
Arthritic Conditions
Stress Fracture
Rheumatoid Arthritis
Joint Replacement
Bone Fracture
Sports Injuries

Emphysema/Chronic Bronchitis
Asthma
Allergies- list below
Latex Sensitivity
Hypothyroid/Hyperthyroid
Headaches
Diabetes
Kidney Disease
Irritable Bowel Syndrome
Hepatitis HIV/AIDS
Sexually Transmitted Diseases
Physical or Sexual Abuse
Raynaud's (Cold Hands and Feet)

Other/Describe____

Surgical/Procedure History
Y/N Surgery for back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for bladder/prostate
Y/N Surgery for bones/joints
Y/N Surgery for abdominal organs
Other/Describe: ____

OB/GYN History
Y/N Childbirth Vaginal Deliveries #__
Y/N Episiotomy #__
Y/N C-Section #__
Y/N Difficult Childbirth #__
Y/N Prolapse or organ falling out
Y/N Vaginal Dryness
Y/N Painful Periods
Y/N Menopause- when? _____
Y/N Painful vaginal penetration
Y/N Pelvic Pain
Other/Describe: ____

All Medications- pills, injection, patch
____
____
____

Over the Counter- Vitamins, etc ____
____

Bladder/ Bowel Habits/ Problems
Y/N Trouble initiating urine system
Y/N Urinary intermittent/slow stream
Y/N Trouble emptying bladder
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage

Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections

Other/Describe: ____

1. Frequency of urination: awake hours: __ times per day, sleep hours __ times per night
2. When you have normal urge to urinate, how long can you delay before you need to use the bathroom? __ minutes, __ hours, __ not at all
3. The usual amount of urine is: __ small __ medium __ large
4. Frequency of bowel movements __ times per day, __ times per week, or _______________
5. When you have an urge to have a bowel movement, how long can you delay it? ___ minutes, ___ hours, ___ not at all
6. If constipation is present describe your management techniques ___________________________
7. Average fluid intake (one glass is 8 oz or one cup) ____ glasses per day
8. Rate a feeling of organ falling out/ prolapse or pelvic heaviness/pressure:
   __ None present
   __ Times per month (specify if related to activity or your period)
   __ With standing for ______ minutes ____ hours
   __ With exertion or straining

Skip question if no leakage/incontinence

9. Bladder Leakage- number of episodes
   __ No leakage
   __ Times per day
   __ Times per week
   __ Times per month
   __ Only with physical exertion/cough
10. On Average, how much urine do you leak?
   __ No leakage
   __ Just a few drops
   __ Wets underwear
   __ Wets outerwear
   __ Wets the floor

Bowel Leakage- number of episodes
   __ No leakage
   __ Times per day
   __ Times per week
   __ Times per month
   __ Only with exertion/strong urge

How much stool do you lose?
   __ No leakage
   __ Stool staining
   __ Small amount in underwear
   __ Complete emptying

11. What form of protection do you wear? (Please complete only one)
   __ None
   __ Minimal protection (Tissue paper/paper towel/pantishields)
   __ Moderate protection (absorbent product, maxipad)
   __ Maximum protection (Specialty product/diaper)
   __ Other ____

On average, how many pad/protection changes are required in 24 hours? __ # of pads