Patient History

Name **Age** **Date**

1. Describe the current problem that brought you here?

   _____

   _____

2. When did your problem begin? _____months ago _____years ago
3. Was your first episode of the problem related to a specific incident? Yes/No
   Please describe and specify date_____
4. Rate your pain on a 0-10 scale, 10 being the worst_____. Describe the pain (i.e. constant, burning, sharp, ache) _____
5. Describe previous treatment or exercises_____
6. What relieves your symptoms?_____
7. Check all activities that aggravate your symptoms

   ___Sitting
   ___Standing
   ___Urinating
   ___Sexual Activity
   ___Changing positions
   ___No activity changes
   ___Light Activity
   ___Cough/Sneeze
   ___Laughing
   ___Lifting/Bending
   ___Run/Weight Lift/Jump
   ___Triggers- Running water
   ___Nervousness/anxiety
8. What are your treatment goals/concerns?

   _____

   _____

9. Have you been a victim of sexual abuse? Y/N

Since the onset of your symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise
Y/N	Unexplained weight change	Y/N	Unexplained weakness
Y/N	Dizziness/Fainting	Y/N	Night Pain/Sweats
Y/N	Changes in bowel/bladder habits	Y/N	Numbness/Tingling

Other_____

Health History: Date of Last physical exam___Tests Performed_____
General Health: Excellent Good Average Poor Occupation_____
Mental Health: Stress Level High__ Med__ Low__ Current Psych therapy? Y/N
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe_____

_____

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

Cancer	Stroke	Alcoholism
Heart Problems	Epilepsy/Seizures	Asthma
High Blood Pressure	Multiple Sclerosis	Allergies
Ankle Swelling	Head Injury	Latex Sensitivity
Anemia	Osteoporosis	Headaches
Low back pain	Chronic Fatigue Syndrome	RA
SIJ/Tailbone bone	Fibromyalgia	Diabetes
Arthritic Conditions	Irritable Bowel Syndrome	STD
Depression	Hepatitis HIV/AIDS	
Anorexia/Bulimia	Joint Replacement	Emphysema/Bronchitis
Smoking history	Bone Fracture	Physical/Sexual Abuse
Vision problems	Sports Injuries	Raynaud's
Hearing Loss	TMJ/Neck pain	Pelvic pain
Hypothyroid	Hyperthyroid	

Other_____

Surgical Procedure History

Y/N Surgery for back/spine	Y/N Surgery for bladder/prostate
Y/N Surgery for brain	Y/N Surgery for bones/joints
Y/N Surgery for female organs	Y/N Surgery for abdominal organs

Other_____

Ob/Gyn History

Y/N Childbirth vaginal deliveries #___	Y/N Vaginal Dryness
Y/N Episiotomy #___	Y/N Painful Periods
Y/N C-Section #___	Y/N Menopause/ When_____
Y/N Painful vaginal penetration	Y/N Prolapse
Y/N Pelvic Pain	

Other_____

Medications- pills, injections, patch	**Start Date**	**Reason for Taking**

Pelvic Symptom Questionnaire

Bladder/Bowel Problems

Y/N Trouble initiating urine
Y/N Urinary intermittent/slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping urine
Y/N Trouble emptying bladder
Y/N Straining or pushing to empty
Y/N Dribbling after urination
Y/N Urine leakage

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

Other_____

1. Frequency of urination: ___times per day ___times per night
2. When you have a normal urge to urinate how long can you delay before you have to go to the toilet?_____
3. The usual amount of urine passed is:___small___medium___large
4. Frequency of bowel movements: ___times per day___times per week
5. When you have a normal urge to have a bowel movement how long can you delay before you have to go to the toilet?_____
6. If constipation is present, describe 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 pressure:

___None
___Times per month (if related to period)
___With standing
___With exertion or straining
___Other

Skip Questions if no leakage/incontinence

9. Bladder leakage
___No leakage
___Times per day
___Times per week
___Times per month
___Only with physical exertion

Bowel leakage
___No leakage
___Times per day
___Times per week
___Times per month
___Only with physical exertion

10. On average how much urine do you leak? How much stool do you lose?

___No leakage
___Just a few drops
___Wets underwear
___Wets outerwear
___Wets the floor

___No leakage
___Stool staining
___Small amount in underwear
___Complete emptying

11. What form of protection do you wear?

___ None

___Minimal protection(tissue paper/pantishields)

___Moderate protection(absorbant pad/maxipad)

___Maximal protection(diaper)

___Other

On average, how many pad/protection changes are needed in 24 hrs? _____# of pads

Patient Demographic Information

Name: _____ DOB: _____ Age: _____

Social Security Number: _____-_____-_____ (Required for Workers comp and blue cross/blue shield patients)

Email Address: _____
(Providing an email address will register you for our quarterly newsletter and provide another means of contact)

Driver's License Number: _____ Issue State: _____

Home Address: _____
CITY STATE ZIP

Home Phone: ( ) - Cell Phone: ( ) -

Employer (required): _____

Employer Address: _____

Occupation (required): _____ Work Number_____

Insurance Subscriber information: (If you, the patient, are the subscriber please put "self")

Name: _____ Social Security:_____

Date of Birth: _____ Subscriber relationship to patient: Spouse/Child/Other:_____

An emergency contact is required below: This person will be contacted in the event that we cannot reach you or there is an emergency during an office visit

Emergency Contact Name: _____

Phone Number: ( ) - Relationship: _____

I hereby authorize my insurance carrier to directly pay Bay Physical Therapy for all professional and medical services rendered to me. This is a direct assignment of my rights and benefits under my policy. I agree to pay in a timely manner and understand all copayments, coinsurances, and deductibles will be collected at the time of service. If I cancel within less than 24 hours or "no show"(Meaning do not call to cancel or come in to keep appointment)I fully understand I will be charged and required to pay a $50.00 fee, payable before making any subsequent appointments. A photocopy of this shall be considered valid and effective. I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in my case. I agree that regardless of my insurance status, I am responsible for any unpaid balance on my account for services rendered. I certify that this information is true and correct to the best of my knowledge. HIPAA

_____ _____
Signature Date

If under 18: _____ _____
Guardian name and signature Date