The Center for Physical Rehabilitation
CHOICE EXPERIENCE COMPASSION
www.pt-cpr.com

# Patient History: Women's Health

**Name** _____ **Age**_____ **Date**_____

1. Describe the current problem that brought you here?_____

_____

2. When did your problem first begin?_____months ago or ___ years ago.

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

_____

4. Since that time is it: staying the _ same _____ getting worse _____ getting better
Why or how?_____

5. If pain is present rate pain on a 0-10 scale 10 being the worst._____ Describe the nature of the pain (i.e. constant burning, intermittent ache)_____

_____

6. Describe previous treatment/exercises_____

_____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than_____ minutes
___ Walking greater than _minutes
___ Standing greater than _____ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list _____

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers -running water/key in door
___ With nervousness/anxiety
___ No activity affects the problem

8. What relieves your symptoms?_____

_____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst __

11. What are your treatment goals/concerns?_____

_____

**Since the onset of your current symptoms have you had:**

| | | | |
|---|---|---|---|
| Y/N | Fever/Chills | Y/N | Malaise (Unexplained tiredness) |
| Y/N | Unexplained weight change | Y/N | Unexplained muscle weakness |
| Y/N | Dizziness or fainting | Y/N | Night pain/sweats |
| Y/N | Change in bowel or bladder functions | Y/N | Numbness / Tingling |
| Y/N | Other /describe_____ | | |

_____

Southeast: 5060 Cascade Rd., Ste. A, Grand Rapids, MI 49546 – 616.954.0950
Southwest: 1736 Gezon Pkwy., Ste. 100, Wyoming, MI 49519 – 616.249.0750
Northeast: 6290 Jupiter Ave., Ste. C, Belmont, MI 49306 – 616.364.3290
Northwest: 1195 Wilson Ave., Ste. 101, Walker, MI 49534 – 616.784.1450

The Center for Physical Rehabilitation
CHOICE EXPERIENCE COMPASSION
www.pt-cpr.com

# Patient History: Women's Health

**Name**_____

**Health History:** Date of Last Physical Exam _____ Tests performed_____
_____

**General Health:** Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
**Mental Health**: Current level of stress 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 /describe**

| | | |
|---|---|---|
| Cancer | Stroke | Emphysema/chronic bronchitis |
| Heart problems | Epilepsy/seizures | Asthma |
| High Blood Pressure | Multiple sclerosis | Allergies-list below |
| Ankle swelling | Head Injury | Latex sensitivity |
| Anemia | Osteoporosis | Hypothyroid/ Hyperthyroid |
| Low back pain | Chronic Fatigue Syndrome | Headaches |
| Sacroiliac/Tailbone pain | Fibromyalgia | Diabetes |
| Alcoholism/Drug problem | Arthritic conditions | Kidney disease |
| Childhood bladder problems | Stress fracture | Irritable Bowel Syndrome |
| Depression | Rheumatoid Arthritis | Hepatitis HIV/AIDS |
| Anorexia/bulimia | Joint Replacement | Sexually transmitted disease |
| Smoking history | Bone Fracture | Physical or Sexual abuse |
| Vision/eye problems | Sports Injuries | Raynaud's (cold hands and feet) |
| Hearing loss/problems | TMJ/ neck pain | Pelvic pain |

Other/Describe_____

Surgical /Procedure History

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

Other/describe_____

Ob/Gyn History (females only)

| | | | |
|---|---|---|---|
| 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 | Difficult childbirth #_____ | Y/N | Painful vaginal penetration |
| Y/N | Prolapse or organ falling out | Y/N | Pelvic pain |
| Y/N | Other /describe_____ | | |

| Medications - pills, injection, patch | Start date | Reason for taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Over the counter -vitamins etc | Start date | Reason for taking |
|---|---|---|
| | | |
| | | |
| | | |

Southeast: 5060 Cascade Rd., Ste. A, Grand Rapids, MI 49546 – 616.954.0950
Southwest: 1736 Gezon Pkwy., Ste. 100, Wyoming, MI 49519 – 616.249.0750
Northeast: 6290 Jupiter Ave., Ste. C, Belmont, MI 49306 – 616.364.3290
Northwest: 1195 Wilson Ave., Ste. 101, Walker, MI 49534 – 616.784.1450

The Center for Physical Rehabilitation
CHOICE EXPERIENCE COMPASSION
www.pt-cpr.com

# Patient History: Women's Health

**Name**_____

## Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

| | | | |
|---|---|---|---|
| Y/N | Trouble initiating urine stream | Y/N | Blood in urine |
| Y/N | Urinary intermittent /slow stream | Y/N | Painful urination |
| Y/N | Trouble emptying bladder | Y/N | Trouble feeling bladder urge/fullness |
| Y/N | Difficulty stopping the urine stream | Y/N | Current laxative use |
| Y/N | Trouble emptying bladder completely | Y/N | Trouble feeling bowel/urge/fullness |
| Y/N | Straining or pushing to empty bladder | Y/N | Constipation/straining |
| Y/N | Dribbling after urination | Y/N | Trouble holding back gas/feces |
| Y/N | Constant urine leakage | Y/N | Recurrent bladder infections |
| Y/N | Other/describe _____ | | |

1. Frequency of urination: awake hour's _____ times per day, sleep hours _____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? _____minutes, _____hours, _____not at all
3. The usual amount of urine passed 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 before you have to go to the toilet? _____minutes, _____hours, _____not at all.
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
   Of this total how many glasses are caffeinated?__ 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 or _____hours.
___With exertion or straining
___Other

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b. 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

# PELVIC FOOR CONSENT FOR EVALUATION AND TREATMENT

**Informed consent for treatment:**

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

**Potential risks:** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

**Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of Wendy Ginsberg, PT and/or Karen Munger, PT

Date_____ Patient Name: _____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

_____
Witness Signature

Southeast: 5060 Cascade Rd., Ste. A, Grand Rapids, MI 49546 – 616.954.0950
Southwest: 1736 Gezon Pkwy., Ste. 100, Wyoming, MI 49519 – 616.249.0750
Northeast: 6290 Jupiter Ave., Ste. C, Belmont, MI 49306 – 616.364.3290
Northwest: 1195 Wilson Ave., Ste. 101, Walker, MI 49534 – 616.784.1450

The Center for Physical Rehabilitation
CHOICE EXPERIENCE COMPASSION
www.pt-cpr.com

# Plan of Care Agreement

My diagnosis, evaluation findings including the treatment program, the expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program, has all been explained to me. My questions about my care have been answered to my understanding and satisfaction. I consent to the recommended course of treatment.

For optimum care and progress:

- It is important to keep your regularly scheduled therapy appointment. At those visits we can advance your exercise routine.
- Please avoid practicing your pelvic floor exercises just before your next appointment time.
- Bring your exercise sheets, voiding log and biofeedback internal sensors as appropriate to each office visit.

_____ _____

Date Patient Name (Please Print)

_____ _____

Patient Signature Signature of Parent or Guardian
(If applicable)

_____

Therapist Signature