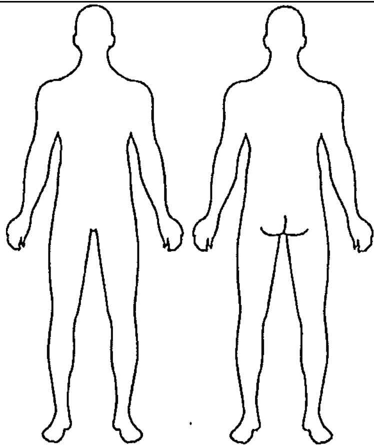
Oakdale OB/GYN

Physical Therapy Patient Questionnaire

Name: ____ **Date:** ____________ **DOB:**_________________

Age: __________________ **Height:**________________ **Weight:**_______________________

What are your symptoms:
Indicate areas of pain or abnormal sensation on the body chart below (shade in where appropriate)



Front **Back**

When did your symptoms begin? (Please indicate a specific date if possible)
On a scale from 1-10 please indicate your level of pain? **(0 begin "no pain" and 10 being "worst pain imaginable")**
Was the onset of this episode gradual or sudden? (please select one) □ Gradual □ Sudden
What is the cause of your symptoms?
Are you currently pregnant? □ NO □YES, how many weeks __________________
Are you currently breastfeeding? □ NO □YES
Nature of pain/symptoms (check all that apply) □ sharp □ aching □ constant □ dull □ periodic □ throbbing □ occasional □other____
As the day progresses, do your symptoms: (check one) □ increase □ decrease □ stay the same
Does the pain wake you at night? □ NO □ YES, how many times a night do you wake**:**_________________________________
Since the onset of your current symptoms have you had: □ any difficulty with control of bowel or bladder function □ fever/chills □ any numbness in the genital or anal area □ numbness □ any dizziness or fainting attacks □ weakness □ unexplained weight changes □ night pain/sweats □ malaise (vague feeling of bodily discomfort) □ problems with vision/hearing □ none of the above

What aggravates your symptoms? (check all that apply)

- □ going to/rising from sitting
- □ household activities
- □ up/down stairs
- □ reaching overhead
- □ reaching in front of body
- □ reaching behind back
- □ reaching across body
- □ getting in/out of bed
- □ getting in/out of car
- □ repetitive activities
- □ lying down
- □ squatting
- □ dressing lower body
- □ dressing upper body
- □ coughing/sneezing
- □ taking a deep breath
- □ looking overhead
- □ stress
- □ sustained bending
- □ other ___________________________________

What relieves your symptoms? (check all that apply)

- □ sitting □ rest □ massage □ heat □ standing
- □ medication □ cold □ walking □ nothing □ stretching
- □ exercise □ lying down □ wearing a splint/orthosis
- □ other:____

Have you had any previous treatment for this condition? (check all that apply)

- □ none □ physical therapy □ medication (oral)
- □ hypnosis □ joint manipulation □ biofeedback
- □ exercise □ TENS unit □ massage therapy
- □ acupuncture □ traction □ bed rest
- □ bracing/taping □ overnight hospitalization □ injection into spine
- □ casting □ injection into skin/muscles
- □ other:____

Have you had any of the following tests?

- □ none □ Arthrogram □ TENS unit
- □ x-ray □ Vestibular □ biofeedback
- □ CT scan □ Bone scan □ MRI
- □ Stress x-ray
- □ other:____
- □ Test Results:____

How long can you tolerate each of the following activates?

Sitting:______________________ Standing:____

Walking:_____________________ Light Housework:__________________________________

Work History:

Occupation:____

- □ employed full-time □ employed part-time □ self employed
- □ homemaker □ student □ retired
- □ unemployed □ other____

Physical activities at work (check all that apply)

- □ sitting □ standing □ phone use □ repetitive lifting □ computer use □ driving
- □ heavy lifting □ other____

Are you currently receiving or seeking diability for this condition? □ NO □ YES

If not performing your normal activities at work do you plan to RETURN to your previous activity level?
□ NO □ YES

Living Situation:
□ live alone □ live with family members □ live with caregiver □ retirement complex
□ home/apartment □ assisted living complex □ other:___________________________________

Setting:
□ stairs (railing) □ no stairs □ stairs (no railing) □ ramp □ elevator □other_________________

Have you fallen in the last year? If so, what were the circumstances?

How would you rate your average health?
□Excellent □ Average □ Good □ Fair □ Poor

Do you use exercise outside of normal daily activities?
□ 5+ days/wk □ 3-4 days/wk □ 1-2 days/wk □ occasionally □ zero

Recreation activities consisting of:
□ running □ golfing □ walking □ biking □ tennis □ skiing □ swimming
□ other:____

Do you drink caffeinated beverage?
□ NO □ YES How many/much per day:____

Do you smoke?
□ NO □ YES Packs of cigarettes per day:____

What is your stress level:
□ low □ medium □ high

Are you seeing any heath care providers other than the physical therapist of the current condition? (please list):

Past Medical History (Have you ever had/been diagnosed with any of the following, check all that apply)

□ Cancer (type)__________________ □ Heart problems □ Depression
□ High blood pressure □ Stroke □ Lung problems
□ Kidney problems □ Blood disorders □Thyroid problems
□ Epilepsy/seizures □ Diabetes □ Allergies
□ Multiple sclerosis □ Rheumatoid arthritis □ Arthritis
□ Osteoporosis □ Head injury □ Broken bone
□ Stomach problems □ Circulation/vascular problems □ Parkinson's disease
□ Infectious disease (i.e. hepatitis, Tuberculosis, etc
□ Other:____

Please list any past surgeries related to your current problem: (include surgery and date)

What are your goals for physical therapy?

Bladder Symptoms: □ NO □ YES (please check all that apply below)

□ Leaking with coughing/sneezing

□ Urinary urgency, list triggers:______________________________________

□ Leaking with urgency

□ Urinary frequency, list number of times urinating during the day ____________, at night ________________

□ Pain with full bladder

□ Pain with urination

□ Unable to fully empty your bladder

Bowel Symptoms: □ NO □ YES (please check all that apply below)

□ Bowel incontinence

□ Bowel urgency

□ Constipation

□ Straining to have a BM

How many BMs do you have per day?_________________ How many BMs do you have per week?____________

Describe the consistency of stool? _____________________________________

Sexual Function:

Do you have pain with vaginal penetration? □ NO □ YES