

# PALMER PHYSICAL THERAPY for WOMEN

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## INCONTINENCE / PELVIC PAIN HISTORY FORM

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ (Confirmed: \_\_\_\_\_)

Referring Physician: \_\_\_\_\_ Next Appt.: \_\_\_\_\_

Occupation/Type of Work: \_\_\_\_\_ Hours per week: \_\_\_\_\_

How did you find out about us?  TV  Radio  Billboard  Website  Doctor  Other \_\_\_\_\_

### Medical History:

Hysterectomy; ( Abdominal or  Vaginal; Are Ovaries intact?  Yes  No) Onset of Menopause \_\_\_\_\_  
Are you being treated with Hormone Replacement Therapy?  Yes  No  Bowel Repair  Back/Neck Surgery  
 Bladder Repair  Heart Disease  Diabetes  Recurrent Bladder/Yeast Infections  Osteoporosis/Osteopenia  
 Lung/Breathing Problems  Arthritis  Hypertension  Cancer  Recent unexplained weight loss  Current  
treatment that suppresses immune function  Fractures  Stroke/CVA  Kidney Problems  Recent accident (if  
yes, explain) \_\_\_\_\_  Metal Implants  Pacemaker

Do you smoke?  Yes  No Other Health Issues: \_\_\_\_\_

Do you have a fear of falling?  Yes  No Have you fallen in the past year?  Yes  No (If yes, how many falls? \_\_\_\_)

Were you injured in a fall in the past year?  Yes  No (If yes, explain \_\_\_\_\_)

Have you ever had a Sexually Transmitted Disease?  Yes  No If yes \_\_\_\_\_

Please list any Allergies: \_\_\_\_\_

Are you pregnant?  Yes  No If yes, how many weeks? \_\_\_\_\_

Has your physician limited any activity?  Yes  No If so, please explain \_\_\_\_\_

Current Medication list: Please bring a copy with you to your appointment (PT received/reviewed  Yes  No)

When did the problem(s) begin? \_\_\_\_\_

Are your symptoms getting worse?  Yes  No

Prior Treatment (No/Yes; if yes provide explanation): \_\_\_\_\_

Where do you have pain?  low back  neck  abdomen/pelvis  
 vagina  rectum  headache/migraines  other: \_\_\_\_\_

Rate your level of pain for your primary complaint from 0 to 10:

0= no pain, 1= very mild, 2= discomforting, 3= tolerable, 4= distressing, 5= very distressing,  
6= intense, 7= very intense, 8= utterly horrible, 9= excruciating, 10= will go unconscious shortly  
\_\_\_\_\_ at worst \_\_\_\_\_ at best \_\_\_\_\_ on average \_\_\_\_\_ current

What makes your pain worse? \_\_\_\_\_

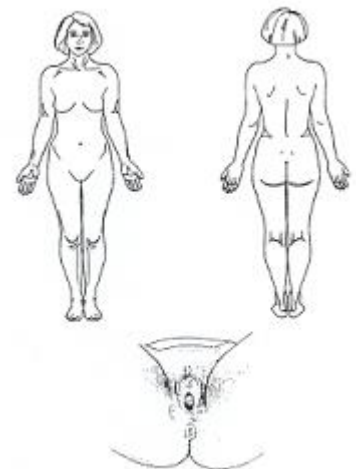
What makes your pain better? \_\_\_\_\_

Do you have pain, numbness or tingling in your:

Legs/feet  Yes  No Arms/hands  Yes  No

Do you participate in sports, hobbies, exercise programs, or activities? \_\_\_\_\_

Mark Area(s) of Pain



*(please complete questions other side)*

Do you leak urine?  Yes  No How long have you had a problem with leaking urine? \_\_\_\_\_

How often do you empty your bladder?

every 4 hrs.  every 3 hrs.  every 2 hrs.  1 hr.  every 30 min.  don't know

How often do you empty your bladder at night?

never or rarely  1 time/night  2 times/night  3 times/night  4 times/night  5 times/night or more

How often do you leak urine?  less than 1 per week  more than 1 per week (#\_\_\_\_ per week)  1 per day  
 more than 1 per day (#\_\_\_\_ per day)  continual leaking

When does leaking occur?  mainly during day  mainly during night  day and night

When you leak, how much do you leak?  a few drops  less than a cup  more than a cup  don't know  
Are you aware that you had leaked?  Yes  No

Do any of the following cause you to leak urine?

exercise  laughing  coughing  sneezing  walking  running water  lifting/straining  
 strong urge to urinate  getting to toilet/removing clothes

When you urinate, do you have:

burning  discomfort or pain  blood in urine  dribbling after  problems with starting the stream

What type of protective devices do you use?

pantyliner  minipad  maxipad  incontinence brief Number of pads/briefs used per day? \_\_\_\_\_

How many cups of fluid do you drink per day? \_\_\_\_\_ Of those, how many are caffeinated and/or carbonated? \_\_\_\_\_

Do you restrict fluids because of your incontinence?  Yes  No

Do you ever experience bowel accidents?  Yes  No If yes, # of times per day \_\_\_\_\_ per week \_\_\_\_\_

Are the accidents only with loose stool?  Yes  No

Do you ever experience fecal staining?  Yes  No Any difficulty holding gas?  Yes  No

Do you require multiple attempts for cleaning after a bowel movement?  Yes  No

Usual frequency of bowel movements \_\_\_\_\_ Any recent change? \_\_\_\_\_

Are you ever constipated?  Yes  No Do you use laxatives?  Yes  No

Consistency of stool \_\_\_\_\_ Do you have pain before or after bowel movement?  Yes  No

Do you feel an urge to have a bowel movement?  Yes  No Do you feel empty after?  Yes  No

Do you have to manually assist to have a bowel movement?  Yes  No

Number of pregnancies \_\_\_\_\_ Number of vaginal deliveries \_\_\_\_\_ Number of C-sections \_\_\_\_\_

Do you ever have painful intercourse?  Yes  No If yes, check when:  Initial entry  Deep penetration

Rate your pain (0 to 10) \_\_\_\_\_ Does pain linger?  Yes  No Is this a new problem?  Yes  No

Do you experience vaginal heaviness or pressure?  Yes  No

What do you expect to accomplish with physical therapy? \_\_\_\_\_

Briefly describe any additional concerns: \_\_\_\_\_