

PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name: _____ Age _____ Why are you here? _____

Check all the Conditions that apply to you:

HEART/CIRCULATION	√	MEDICAL PROBLEMS	√	CHILDBEARING HISTORY	
Heart Disease/Surgery		Diabetes		Are you Pregnant? Yes No If yes, what is your due date: _____	
High Blood Pressure		Cancer		# of Children (circle one number)	0 1 2 3 4 5 +
Pain/tightness in chest		Thyroid Problems		# of Vaginal deliveries (circle)	0 1 2 3 4 5 +
Cold Hands/feet		Autoimmune disease		# of C-Sections (circle one number)	0 1 2 3 4 5 +
Numbness in hands/feet		Depression		# of episiotomies (circle one number)	0 1 2 3 4 5 +
		LUNG/BREATHING		# of forceps deliveries	0 1 2 3 4 5 +
BONES & JOINTS		Shortness of Breath		Birth weight of largest baby	
Chronic Fatigue Syndrome		Smoke cigarettes now		GYNECOLOGICAL HISTORY	
Arthritis		History of smoking		Date of Last Pap Smear: _____	
Fibromyalgia		FAMILY HISTORY		Do you have pain with sexual intercourse	Yes No NA
Tailbone pain		Skin cancer		History of Candida/Genital Herpes/ Yeast	Yes No
Joint Replacements		Allergies		Do you have any current infections or yeast	Yes No
AREAS OF PAIN		Heart disease		Do you use Bath salts, vaginal sprays, deodrant	Yes No
Back		High Blood Pressure		Do you use vaginal lubricants or ___KY jelly	Yes No
Neck/shoulders		SURGICAL HISTORY		Do you use latex condoms	Yes No
Rectal area		Back or neck		URINARY/BLADDER HISTORY	
Abdomen/belly		Tubal Ligation		Do you have bladder pain	Yes No
Vagina		Laproscopy		Do you have "burning" with urination	Yes No
Vulvar (near the vagina)		Abdominal Hysterectomy		Do you have feeling of pressure in your bladder	Yes No
Buttocks		Vaginal Hysterectomy		Do you have interstitial cystitis	Yes No
		Gall Bladder		Do you trouble starting a urine stream?	Yes No
ALLERGIES		Bladder surgery		Do you have frequent bladder infections?	Yes No
Ragweed		Pelvic Surgery		Have you had one or more urethral dilations?	Yes No
Food allergies		Vaginal Surgery/laser		Do you have a falling out feeling _____Yes _____No	
Latex allergies (Exam gloves, condoms)		Vulvar Surgery		If yes ___ Sometimes with menses ___ Standing ___ Straining	
Seasonal Allergies		Pudendal Nerve Surgery		___ At the end of the day ___ All the time	
SKIN CONDITIONS				BOWEL HISTORY	
Eczema				Do you leak gas or feces	Yes No
Contact Dermatitis		FALLS, TRIPS, SLIPS		Do you have constipation	Yes No
Psoriasis		Dizziness		Do you strain to have a bowel movement	Yes No
Lichens Simplex		#Falls the last 6 mos.		Is your stool ___pencil thin ___pellets ___large	
		# trips/slips/near falls		___ Liquid ___ Soft (like peanut butter) ___ Firm (like banana) ___ Hard	
				How often do you have a bowel movement:	
				___ 2 or more x per day ___ Daily ___ Every other day ___ Every 4-7 days	

LIST ALL THE MEDICATIONS YOU ARE TAKING, INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS:

Name of Medication	For what?	Name of Medication	For What?

If you have Urinary Leakage, please complete this Section

HOW OFTEN DO YOU LEAK URINE?

- 0=Never
- 1=1-4/month
- 2=2-4/week
- 3=X1/day
- 4=more than once/day

WHAT TYPE OF PROTECTION DO YOU USE?

- 0=None
- 1=panty liner
- 2=mini pad
- 3=maxi pads
- 4=Poise/Depends

HOW MUCH URINE DO YOU LEAK?

- 0=None
- 1=Few Drops
- 2=Soak panty liner/underwear
- 3=soak pad/outerwear
- 4=runs down my leg

NUMBER OF PADS PER DAY

- 0=None
- 1=with some activity
- 2=1/day
- 3= 2-4/day
- 4= more than 4/day

5. WHAT ACTIVITIES CAUSE LEAKAGE?

- 0= None
- 1= Light
- 2=Moderate
- 3=Vigorous
- 4= All physical activity

What are your goals?

- _____ Less Leakage
- _____ Less waking up at night to urinate
- _____ Not wearing pads for leakage
- _____ Not leaking with activity _____
- _____ Less Frequency _____ Less Urgency

If you urinate too often or have a sense of Urinary Urgency, please complete this section

DO YOU URINATE TOO OFTEN? (MORE THAN ONCE EVERY 2 HOURS)

- 0=No problem
- 1= very small problem
- 2=Small problem
- 3= medium problem
- 4=Big Problem

IS YOUR SLEEP DISTURBED BY GOING TO THE BATHROOM TOO OFTEN?

- 0=No problem
- 1= very small problem
- 2=Small problem
- 3= medium problem
- 4=Big Problem

DO YOU HAVE THE NEED TO URINATE WITHOUT WARNING (URINARY URGENCY)?

- 0=No problem
- 1= very small problem
- 2=Small problem
- 3= medium problem
- 4=Big Problem

DO YOU HAVE LEAKAGE WITH URGENCY? (CAN'T MAKE IT TO THE BATHROOM ON TIME)

- 0=No problem
- 1= very small problem
- 2=Small problem
- 3= medium problem
- 4=Big Problem

Effect of Problem on Daily Life 0=no problem 1= very small problem 2=small problem 3= medium problem 4=big problem

	0	1	2	3	4	Comments
Affects my choice of clothing						
Affects my ability for housework						
Cannot travel more than one hour without using bathroom						
Interferes with social activity (movies, dancing, church, visiting)						
Affects my sex life/relationship with partner						
I feel depressed, anxious, embarrassed, frustrated, angry						
I worry that I smell						
I withhold fluids for fear of leakage or frequency						

SOCIAL, OCCUPATIONAL AND RECREATIONAL ACTIVITIES

Marital Status: Single Married Separated Divorced Dating

Do you feel safe at home? Yes No Comment: _____

Occupation: _____ Physically this means I sit stand walk most of the day

Educational Level _____ **Hobbies:** _____

EXERCISE HISTORY:

No exercise Walk _____ Go to gym _____

Other _____

CHECK THE WORDS THAT APPLY TO HOW YOU FEEL THESE DAYS &/OR CHOOSE YOUR OWN WORDS:

DESCRIPTOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Happy →	<input type="checkbox"/>	Calm →	<input type="checkbox"/>	Unmotivated	<input type="checkbox"/>	Stressed	<input type="checkbox"/>	Lonely	<input type="checkbox"/>	Content	<input type="checkbox"/>	Depressed	<input type="checkbox"/>
Overwhelmed →	<input type="checkbox"/>	Sad →	<input type="checkbox"/>	Tired	<input type="checkbox"/>	Afraid	<input type="checkbox"/>	Energetic	<input type="checkbox"/>	Optimistic	<input type="checkbox"/>	“Postpartum blues”	<input type="checkbox"/>
Flabby →	<input type="checkbox"/>	Strong →	<input type="checkbox"/>	Un-rested	<input type="checkbox"/>	Lethargic	<input type="checkbox"/>	Weak	<input type="checkbox"/>	Overworked	<input type="checkbox"/>	Not bonding with baby(ies)	<input type="checkbox"/>
Anxious →	<input type="checkbox"/>	Unsafe →	<input type="checkbox"/>	Abused	<input type="checkbox"/>	Neglected	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

HOW DO YOU LEARN?: Listening (lecture, discussion) Seeing (read, video, DVD) Doing (practicing skill)

Is English your primary language? Yes No. If no, would you need a translator when you are in therapy? _____

NUTRITION: How much do you weigh? _____ pounds

Would you like to <input type="checkbox"/> lose or <input type="checkbox"/> gain weight?	Yes No	
Have you gained/ lost more than 10 pounds in the last year?	Yes No	
Are you on any special diet?	Yes No	<input type="checkbox"/> Low Carb <input type="checkbox"/> Atkins <input type="checkbox"/> South Beach <input type="checkbox"/> Weight Watchers <input type="checkbox"/> Diabetic <input type="checkbox"/> Other _____
Would you say your diet is “unhealthy”?	Yes No	<input type="checkbox"/> too many fast foods <input type="checkbox"/> Not enough vegetables <input type="checkbox"/> High Fat <input type="checkbox"/> High Carb <input type="checkbox"/> Other _____

FLUID INTAKE: What do you drink every day?

8 ounce glasses of water cans of diet soda cans of regular soda 8 ounce cups of regular coffee
 8 ounce cups of decaffeinated coffee 8-ounce cups/glasses of tea 16-ounce cans of beer
 glasses of wine glasses of liquor 8-ounce glasses of milk 8-ounce glasses of juice _____
 Other _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? None or:

TREATMENTS	HAS IT HELPED?	TREATMENTS	HAS IT HELPED?
Medication(s)	Yes No A little	Surgery	Yes No A little
Physical Therapy	Yes No A little	Other	Yes No A little

IF YOU HAVE PELVIC AND/OR SEXUAL PAIN, PLEASE COMPLETE THIS PAGE:

CURRENT SEXUAL ACTIVITY:

Sexually Inactive due to PAIN Sexually inactive due to bladder problem Sexually active

If you are sexually active, continue with this section.

No pain with intercourse Pain with intercourse, able to complete coitus Pain with intercourse disrupts or prevents coitus
 Pain with intercourse prevents any attempt at coitus

CHECK ALL THE ACTIVITIES THAT CAUSE OR INCREASE YOUR PAIN: No Pain or Pain with:

Gynecological Examination with Speculum Urination after intercourse Finger insertion into vagina
 Tampon insertion Tampon removal Partner manual stimulation Friction with clothing Sports activity
 Urination in general Wearing pads
 Other _____

CHECK THE WORDS THAT DESCRIBE YOUR PAIN: No Pain or Pain is:

Hot Burning searing Sharp Tiring Exhausting frightful punishing Annoying
 Troublesome miserable intense unbearable discomfoting Other _____

WHAT MAKES YOUR PAIN BETTER: NO Pain or Pain is relieved with:

Heating pad Ice pack Resting in bed Resting in Chair Medication Cream _____
 Abstaining from sexual intercourse Not using tampons Not wearing tight clothes other _____

What started this problem? _____

Comments

Anything else you would like us to know about you?

DAILY VOIDING DIARY

Name: _____ Date: _____

Keep an accurate diary throughout the day. Try to bring in 2 diaries to your first appointment.

Instructions:

1. Mark wake ups and bedtimes.
2. Mark fluids in ounces. Add up your fluid intake and put on bottom.
3. Be accurate to the minute with the time in the day that you void.
4. Count and record the seconds voided (“one-one-thousand”=1 second)
5. Document your bowel movements with “B.M.”
6. Document under “other comments” things like pain, burning, post-void dribble, double void, etc.

	Time	Type/Amount Food & Fluid	Amount Voided SM/MD/LG	Leakage SM/MD/LG	Urge 0/+/+/+/+	Activity with Leakage	Other Comments
am	12						
	1						
	2						
	3						
	4						
	5						
	6						
	7						
	8						
	9						
	10						
pm	11						
	12						
	1						
	2						
	3						
	4						
	5						
	6						
	7						
	8						
	9						
10							
11							

Number of pads used _____