Bacharach INSTITUTE FOR REHABILITATION

Pelvic Floor Patient History

Summary List

Patient Name: _____

DOB: _____ Acct #: _____

Patient Identification

Eval. Date: _____

Diagnosis: _____

What language are you most comfortable speaking with your therapist?

_____

Would you like an interpreter? ___ Yes ___ No

_____

HISTORY OF CURRENT PROBLEM

1. Describe the current problem that brought you here?

   _____

   _____

2. When did your problem 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?

   _____

Rate the severity of this problem from 0 – 10 with 0 being no problem and 10 being the worst _____.

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. Date of Last Physical Exam _____ Tests performed:

   _____

   _____

7. Describe previous treatment/exercises

   _____

   _____

8. 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. 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 (i.e. sit to stand)
___Light activity (light housework
___Vigorous activity/exercise (run/weight lift/jump)
___Sexual activity
___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

___ Other, please list _____

11. What relieves your symptoms? _____

_____

12. What are your treatment goals / concerns?

HISTORY OF CURRENT PROBLEM (cont'd)

13. Since the onset of your current symptoms, have you had: (Check all that apply.)

___ Fever/Chills
___ Malaise (Unexplained tiredness)
___ Unexplained weight change Y/N
___Unexplained muscle weakness
___ Dizziness or fainting
___Night pain/sweats
___Change in bowel or bladder functions
___Numbness/tingling
___Other/describe: _____

_____

GENERAL HEALTH

___Excellent ___Good ___Average ___Poor

Activity/Exercise:

___ None ___1-2 days/week
___ 3-4 days/week ___ 5+ days/week

Describe: _____

_____

Mental Health: Current level of stress:

___ High ___ Medium ___ Low

Current psych therapy? ___ Yes ___ No

FOR WOMEN: Are you pregnant, or think you might be pregnant? ___Yes ___ No

Do you have a history of a resistant bacteria, such as MRSA? Or if hospitalized, did staff wear gowns and gloves each time they entered the room? ___Yes ___No

Have you traveled outside the U.S. in past 30 days? ___ No ___ Yes-please tell us where:

_____

FALL RISK ASSESSMENT

Have you fallen in the past three months? ___Yes ___ No

ABUSE SCREENING

Do you have any concerns about physical, emotional, or sexual abuse? __Yes ___No

Would you like to talk to someone about your situation? ___Yes ___No

Bacharach can discuss my health information with the following persons who are involved in my care:

_____

_____

_____ ☐None

PELVIC FLOOR HISTORY FORM / SUMMARY LIST

All questions must be completed by the third visit to Bacharach.

Patient Identification

MEDICAL HISTORY

Please check any conditions you have: ___ **None**

__ Alcoholism/Drug problem
__Anemia
__Ankle swelling
__Anorexia/bulimia
__Arthritic conditions
__Asthma
__Bone fracture
__Cancer
__Childhood bladder problem
__Chronic Fatigue Syndrome
__Depression
__Diabetes
__Emphysema/chronic bronchitis
__Epilepsy/seizures
__Fibromyalgia
__Head injury
__Headaches
__Heart problems
__Hearing loss/problems
__Hepatitis HIV/AIDS
__High blood pressure
__Hypothyroidism/ Hyperthyroidism
__Irritable Bowel Syndrome
__Kidney Disease
__Joint Replacement
__Low Back Pain
__Multiple sclerosis
__Osteoporosis
_Pelvic Pain
__Raynaud's (cold hands/feet)
__Rheumatoid Arthritis
__Sacroiliac/Tailbone pain
__Sexually transmitted disease
__Sports Injuries
__Stress fracture
__Stroke
__ TMJ/Neck Pain
__ Vision/eye problems

Other: _____

Surgical Procedure History (check all that apply)

__ back/spine
__ brain
__ female organs
__ bladder/prostrate
__ bones/joints
__ abdominal organs
__ Other: _____

OB/GYN History (females only)

__Childbirth vaginal deliveries # ___
__Episiotomy # ___
__C-section # ___
__Difficult childbirth # ___
__Prolapse or organ falling out
__ Painful vaginal penetration
__vaginal dryness
__painful periods
__ Menopause? When _____
__ Pelvic pain
__ Other: Describe _____
_____

Males only

__ Prostate disorders
__ Shy bladder
__ Pelvic pain
__ Erectile dysfunction
__ Painful ejaculation
__ Other: Describe _____
_____

MEDICATIONS

Please list your current medications and their purposes (pain relief, arthritis, etc) taken for this injury/condition:

MEDICATION	PURPOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all other medications/purposes: (including over-the-counter medications, vitamins, and herbs)

_____	_____
_____	_____
_____	_____

Not taking any medication for this problem. _____

ALLERGIES

☐ None

Check if you ever had the following):

Allergies: __ Medication __Food __Environmental __Latex

Please list all known allergies and adverse drug reactions(attach separate sheet if needed)

_____

HEALTH HABITS

Do you currently smoke/chew tobacco? ___Yes ___No
Cigarettes/Cigars ___ # packs/day
Smoke in the past? ___Yes ___ No; Years quit? _____

EDUCATION/EMPLOYMENT

Highest grade completed (circle one)
1 2 3 4 5 6 7 8 9 10 11 12
__College/Technical School/Vocational School
__College Graduate __ Advanced/Graduate Degree
Your occupation?_____
Hours/week _____ On disability or leave? ____
Activity Restrictions? _____
Leisure interests:_____
Method you learn best: ___Watching ___Listening ___Doing ___Having written information

CULTURAL/RELIGIOUS:

Do you have any customs, religious beliefs, or wishes that might affect care?

_____

☐ None

Are you seeing anyone else for this problem? (check all that apply) ☐Acupuncturist ☐ None

☐Cardiologist ☐Orthopedist ☐Chiropractor ☐Osteopath ☐Dentist ☐Massage Therapist
☐Podiatrist ☐Internist ☐Rheumatologist ☐Neurologist ☐ENT ☐Primary Care Doctor
☐Pediatrician ☐Obstetrician/Gynecologist ☐Occupational Therapist ☐Other: _____

Completed by: _____ Date: _____ Time: _____

Reviewed by: _____ Date: _____ Time: _____