Revive Physical Therapy & Pelvic Health at **Desert PT**
5040 E. Shea Blvd. Suite 261
Scottsdale, AZ 85254
602-264-3369(P) 602-264-3368(F)

Patient Health History Form

Patient Name: _____ Date: _____
DOB: _____ Age: ____ Referring Provider: _____
Currently working? Yes or No Occupation: _____

Reason for Physical Therapy: _____
_____
When did this problem start? _____
Did a specific incident cause it? If yes, please describe: _____
_____
Are your symptoms _____staying the same, _____getting better, _____getting worse?

Have you had physical therapy in the past for these symptoms? Yes or No (circle)
What are your goals for Physical Therapy?_____
Medications (include reasons and supplements): _____
_____
Allergies: _____

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

Other /describe: _____

Please indicate if you are experiencing or have experienced any of the following:

	Anemia		Hearing Loss		Osteoporosis
	Arthritis		Hepatitis		Pacemaker
	Asthma		High Blood pressure		Pelvic Pain
	Blood Disorders		HIV/AIDS		Physical Abuse
	Cancer		Hypo/Hyperthyroid		Sexual Abuse
	Depression		IBS		STD's
	Diabetes		Interstitial Cystitis		Stroke
	Epilepsy/Seizures		Kidney Disease		TIA
	Head Injury		Low back pain		TMJ
	Headaches		Neck pain		Vision Problems

Any other conditions that I should be aware of? _____

Surgeries	**Date**	**Reason**
Abdominal		
Bladder		
Bowel		
Uterine		
Orthopedic/Spine		
Heart		
Lungs		
Plastics		
Other		

Childbearing History:

Are you currently Pregnant? Yes/No Due Date:_____
Number of Children:_____ Number of Vaginal deliveries:_____
Number of C-sections:_____ Number of episiotomies:_____
Number of forceps deliveries:_____ Any complications?:_____

Current Sexual Activity: (check all that apply)

____ Sexually Inactive due to pain
____ Pain with Penetration ____Pain with Climax
____ Pain after intercourse? How long does it last? _____
____ Sexually inactive due to other reasons
____ No pain with intercourse

Bladder:

Y / N Difficulty initiating urine stream? **Y / N** Pain during urination?
Y / N Sensation of incomplete bladder emptying? **Y / N** Blood in urine?
Y / N Urine loss with sneezing, coughing, laughing? **Y / N** Insensible urine loss?
Y / N Urine loss with urgency to void? **Y / N** Dribbling after urination?
Y / N Straining to empty bladder?
Is urine stream **weak**, **strong**, or **does it stop start**? (circle)
How many times a day do you void? _____ Per Night? _____
Do you wear pads? **Yes** or **No** How many per day/week? _____
Do you have a sensation of something "falling out"? **Yes** or **No**

Bowel:

Y/N Loss of stool beyond your control? **Y/N** Straining to empty bowels?
Y/N Pain during bowel movements? **Y/N** Sensation of incomplete bowel movements?
Y/N Loss of flatulence (gas) beyond your control?
How Many bowel movements per day/week? _____
Is your stool (circle): **Loose/Liquid Soft Hard Pellets**

If you are experiencing pain, please indicate your pain level below:

0_____10

0= no pain **10=ER Visit**

How would you describe your pain? (circle all that apply)

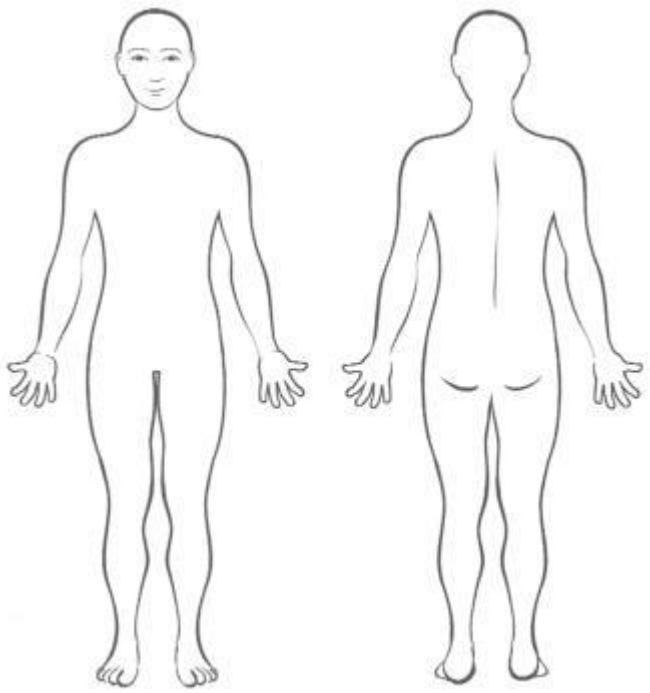
Aching	Stabbing	Shooting	Sharp	Dull
Constant	Tingling	Intermittent	Pressure	Numb

Other: _____

What increases your pain? _____

What decreases your pain? _____

Indicate where you are having pain below:



Front **Back**

Please indicate your stress level below:

_____

0=no stress **10= extreme stress**