

INNER STRENGTH PHYSICAL THERAPY
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Patient History

Name _____ Age _____ Date _____

1. Describe the current problem that brought you here? _____

2. When did your problem first 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? _____

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. Describe previous treatment/exercises _____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

<input type="checkbox"/> Sitting greater than _____ minutes	<input type="checkbox"/> With cough/sneeze/straining
<input type="checkbox"/> Walking greater than _____ minutes	<input type="checkbox"/> With laughing/yelling
<input type="checkbox"/> Standing greater than _____ minutes	<input type="checkbox"/> With lifting/bending
<input type="checkbox"/> Changing positions (ie. - sit to stand)	<input type="checkbox"/> With cold weather
<input type="checkbox"/> Light activity (light housework)	<input type="checkbox"/> With triggers -running water/key in door
<input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump)	<input type="checkbox"/> With nervousness/anxiety
<input type="checkbox"/> Sexual activity	<input type="checkbox"/> No activity affects the problem
<input type="checkbox"/> Other, please list _____	

8. What relieves your symptoms? _____

9. 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. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst ____

11. What are your treatment goals/concerns? _____

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
Y/N	Other /describe _____		

Health History: Date of Last Physical Exam _____ Tests performed _____

General Health: Excellent Good Average Fair Poor Occupation _____

Hours/week _____ On disability or leave? _____ Activity Restrictions? _____

Mental Health: Current level of stress High ___ Med ___ Low ___ Current psych therapy? Y/N

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week

Describe _____

Have you ever had any of the following conditions or diagnoses? Circle all that apply.

- | | | |
|----------------------------|--------------------------|---------------------------------|
| Cancer | Stroke | Emphysema/chronic bronchitis |
| Heart problems | Epilepsy/seizures | Asthma |
| High Blood Pressure | Multiple sclerosis | Allergies -list below |
| Ankle swelling | Head Injury | Latex sensitivity |
| Anemia | Osteoporosis | Hypothyroid/ Hyperthyroid |
| Low back pain | Chronic Fatigue Syndrome | Headaches |
| Sacroiliac/Tailbone pain | Fibromyalgia | Diabetes |
| Alcoholism/Drug problem | Arthritic conditions | Kidney disease |
| Childhood bladder problems | Stress fracture | Irritable Bowel Syndrome |
| Depression | Rheumatoid Arthritis | Hepatitis HIV/AIDS |
| Anorexia/bulimia | Joint Replacement | Sexually transmitted disease |
| Smoking history | Bone Fracture | Physical or Sexual abuse |
| Vision/eye problems | Sports Injuries | Raynaud's (cold hands and feet) |
| Hearing loss/problems | TMJ/ neck pain | Pelvic pain |

Other/Describe _____

Surgical /Procedure History

- | | | | |
|-----|--------------------------------|-----|-----------------------------------|
| Y/N | Surgery for your back/spine | Y/N | Surgery for your bladder/prostate |
| Y/N | Surgery for your brain | Y/N | Surgery for your bones/joints |
| Y/N | Surgery for your female organs | Y/N | Surgery for your abdominal organs |

Other/describe _____

Ob/Gyn History (females only)

- | | | | |
|-----|-------------------------------------|-----|-----------------------------|
| Y/N | Childbirth vaginal deliveries # ___ | Y/N | Vaginal dryness |
| Y/N | Episiotomy # ___ | Y/N | Painful periods |
| Y/N | C-Section # ___ | Y/N | Menopause - when? ___ |
| Y/N | Difficult childbirth # ___ | Y/N | Painful vaginal penetration |
| Y/N | Prolapse or organ falling out | Y/N | Pelvic pain |

Y/N Other /describe _____

Males only

- | | | | |
|-----|--------------------|-----|----------------------|
| Y/N | Prostate disorders | Y/N | Erectile dysfunction |
| Y/N | Shy bladder | Y/N | Painful ejaculation |

Y/N Other /describe _____

Medications - pills, injection, patch Start date Reason for taking

Over the counter -vitamins etc Start date Reason for taking

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream	Y/N Blood in urine
Y/N Urinary intermittent /slow stream	Y/N Painful urination
Y/N Trouble emptying bladder	Y/N Trouble feeling bladder urge/fullness
Y/N Difficulty stopping the urine stream	Y/N Current laxative use
Y/N Trouble emptying bladder completely	Y/N Trouble feeling bowel/urge/fullness
Y/N Straining or pushing to empty bladder	Y/N Constipation/straining
Y/N Dribbling after urination	Y/N Trouble holding back gas/fece
Y/N Constant urine leakage	Y/N Recurrent bladder infections
Y/N Other/describe _____	

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all
3. The usual amount of urine passed is: ____ small ____ medium____ large.
4. Frequency of bowel movements ____ times per day, _____times per week, or _____.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all.
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated? ____ glasses per day.
8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
 None present
 Times per month (specify if related to activity or your period)
 With standing for _____ minutes or _____hours.
 With exertion or straining
 Other _____

Skip questions if no leakage/incontinence

- | | |
|--|---|
| <p>9a. Bladder leakage - number of episodes</p> <input type="checkbox"/> No leakage
<input type="checkbox"/> Times per day
<input type="checkbox"/> Times per week
<input type="checkbox"/> Times per month
<input type="checkbox"/> Only with physical exertion/cough | <p>9b. Bowel leakage - number of episodes</p> <input type="checkbox"/> No leakage
<input type="checkbox"/> Times per day
<input type="checkbox"/> Times per week
<input type="checkbox"/> Times per month
<input type="checkbox"/> Only with exertion/strong urge |
| <p>10a. On average, how much urine do you leak?</p> <input type="checkbox"/> No leakage
<input type="checkbox"/> Just a few drops
<input type="checkbox"/> Wets underwear
<input type="checkbox"/> Wets outerwear
<input type="checkbox"/> Wets the floor | <p>10b. How much stool do you lose?</p> <input type="checkbox"/> No leakage
<input type="checkbox"/> Stool staining
<input type="checkbox"/> Small amount in underwear
<input type="checkbox"/> Complete emptying |

11. What form of protection do you wear? (Please complete only one)
-
- None
-
-
- Minimal protection (Tissue paper/paper towel/pantishields)
-
-
- Moderate protection (absorbent product, maxipad)
-
-
- Maximum protection (Specialty product/diaper)
-
-
- Other _____

On average, how many pad/protection changes are required in 24 hours? _____# of pads