



Women's Center for Wellness and Rehabilitation

Evaluation for Trunk, pelvis and leg pain – Pregnancy and Postpartum

DEMOGRAPHIC AND INSURANCE INFORMATION (PHYSICAL THERAPY DEPARTMENT)

PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name: _____ Why are you here? _____

Check all the Conditions that apply to you:

HEART/CIRCULATION	v	MEDICAL PROBLEMS	v	FOR WOMEN ONLY
Heart Disease		Diabetes		<u>CHILDBEARING HISTORY</u>
<input checked="" type="checkbox"/> High Blood Pressure		Fainting Spells		Are you Pregnant? Yes No
Pacemaker		Cancer		If yes, what is your due date: _____
Heart Surgery		<input checked="" type="checkbox"/> Dizziness		
Pain/tightness in chest		Thyroid Problems		If yes, are you planning to breastfeed? Yes No Don't Know
<input checked="" type="checkbox"/> Stroke		<input checked="" type="checkbox"/> Falls the last 6 mos.		# of Pregnancies – If this is your first pregnancy, skip the next section 0 1 2 3 4 5 +
BONES & JOINTS		<input checked="" type="checkbox"/> # trips/slips/near falls		COMPLETE THE SECTION BELOW ONLY IF YOU HAVE HAD MORE THAN ONE PREGNANCY.
Osteoporosis		<input checked="" type="checkbox"/> Depression		# of Children (circle one number) 0 1 2 3 4 5 +
Scoliosis		LUNG/BREATHING		# of Miscarriages (circle one number) 0 1 2 3 4 5 +
Fibromyalgia		Difficulty breathing		# of Vaginal deliveries (circle) 0 1 2 3 4 5 +
Plantar fasciitis		Shortness of Breath		# of C-Sections (circle one number) 0 1 2 3 4 5 +
Dropped arches/flat feet		Smoke cigarettes now		Birth weight of largest baby
<input checked="" type="checkbox"/> Numbness in feet/legs		History of smoking		# of episiotomies (circle one number) 0 1 2 3 4 5 +
Tailbone fracture		SURGICAL HISTORY		# of forceps deliveries 0 1 2 3 4 5 +
Joint Replacements		Back or neck		IF YOU ARE NOT PREGNANT, PLEASE COMPLETE THE SECTION BELOW
Swelling in Ankles/feet		Tubal Ligation		Are you trying to get pregnant Yes No
AREAS OF PAIN		Laproscopy		Do you have symptoms of leaking urine Yes No
Back ("sciatica like pain")		Abdominal Hysterectomy		Do you have constipation Yes No
Neck		Vaginal Hysterectomy		Do have pain with sexual intercourse Yes No
Ribs		Gall Bladder		
Shoulders		Bladder surgery		
Abdomen/belly		FAMILY HISTORY		
Tailbone		Heart Disease		
Wrist ("carpal tunnel")		High Blood Pressure		
Swelling in the hands		Diabetes		
Feet		Cancer		
Knees		Stroke		
Hips		Osteoporosis		
Other				

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

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

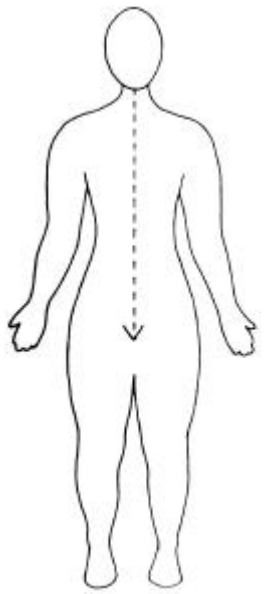


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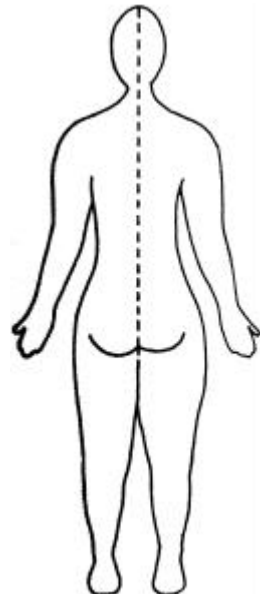
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TELL US ABOUT YOUR PAIN

Please mark with an "X" where your pain begins. Shade any other areas of pain



FRONT



BACK

CHECK ALL THE WORDS THAT DESCRIBE YOUR PAIN:

Numb Stabbing Burning Irritating Aching Throbbing Tender Unbearable Shooting
 Sharp Constant Other _____

WHAT MAKES YOUR PAIN WORSE?

Sitting standing Walking Getting out of bed exercise sexual intercourse menses
 Getting up from sitting position Working at home all day Being at work all day Exercise
 Other _____

WHAT MAKES YOUR PAIN BETTER?

Heating pad Ice pack Resting in bed Resting in Chair walking Medication Exercise
 Other _____

CHECK ALL THE STATEMENTS THAT ARE TRUE:

I have numbness or tingling in my legs I have numbness or tingling in my arms or hands
 There is a change in the way my bladder or bowels work since this problem started
 I feel dizzy I have blurred vision.

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

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