



Orthopedic & TMJ Physical Therapy Center

Confidential Health Questionnaire

Bowel Disorders

Name: _____

D.O.B.: _____

Date: _____

Occupation: _____

General Health Questions

1. Have you ever had any of the following conditions or problems? Be descriptive when appropriate.

- | | | |
|--|---|---|
| <input type="radio"/> Anemia | <input type="radio"/> Heart condition | <input type="radio"/> Renal Disease |
| <input type="radio"/> Arthritis | <input type="radio"/> Hemophilia | <input type="radio"/> Respiratory problems |
| <input type="radio"/> Asthma | <input type="radio"/> Hemorrhoids | <input type="radio"/> Seizures |
| <input type="radio"/> Cataracts | <input type="radio"/> High/low blood pressure | <input type="radio"/> Skin Conditions |
| <input type="radio"/> Cancer | <input type="radio"/> HIV, AIDS | <input type="radio"/> Thyroid problems |
| <input type="radio"/> Chest Pains | <input type="radio"/> Irritable Bowel | <input type="radio"/> Vascular Disease |
| <input type="radio"/> Circulatory problems | <input type="radio"/> Kidney/Bladder Stones | <input type="radio"/> Musculoskeletal |
| <input type="radio"/> Constipation/Impaction | <input type="radio"/> Migraines | <input type="radio"/> TMJ <input type="radio"/> Shoulders |
| <input type="radio"/> Convulsions | <input type="radio"/> Mitral valve prolapse | <input type="radio"/> Neck <input type="radio"/> Hips |
| <input type="radio"/> Diabetes | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Back <input type="radio"/> Knees |
| <input type="radio"/> Digestive problems | <input type="radio"/> Osteoporosis | <input type="radio"/> Feet |
| <input type="radio"/> Dizziness | <input type="radio"/> Osteomyelitis | |
| <input type="radio"/> Eliminatory problems | <input type="radio"/> Pacemaker | |
| <input type="radio"/> Falls | <input type="radio"/> Parkinson's Disease | |
| <input type="radio"/> Fractures | <input type="radio"/> Polyps | Other _____ |
| <input type="radio"/> Head aches | <input type="radio"/> Phlebitis | _____ |
| <input type="radio"/> Head Injuries | <input type="radio"/> Pregnancy Trauma | |

2. When was your last Medical exam? Within last month Within last 6 months More than 6 mo.

3. Have you ever been diagnosed for cancer, a tumor, or noticed any lumps or swellings? Yes No

4. Do you Smoke? Yes No

5. Do you drink alcohol (if so list # per week)? No. ___Beer. ___Wine. ___Spirits.

6. Education High School College Graduate Professional Training

7. Are you currently under the care of a physician/chiropractor/therapist/acupuncturist, counselor,... etc?
Provider's Name & Specialty

8. Have you ever been treated for any of the following: Anxiety Depression Nervous Problems
 Drug Addiction Alcoholism

9. Do you experience:
 Numbness/tingling/weakness in anywhere in your body
 Pain or discomfort with sexual activity
 Clicking, popping, or pain in your jaw

10. Please list any past injuries and/or accidents (include dates if possible):

11. Have you ever seen a physical therapist before? Yes No

12. Please list all medications you are currently taking (prescription and over the counter)?

Name & Dosage

Reason for taking

Name & Dosage	Reason for taking
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

13. Daily Fluid Intake & Diet:

Indicate what amount you drink of the following in a typical day. Water (8oz.) Juice (8oz.)

Coffee (cups) Tea (cups) Soda (8oz.) Do you restrict fluids Yes No

Please describe your diet.

Allergies: medication, food or other

14. Bowel Habits:

How often do you have a bowel movement?

Are you ever constipated?

How do you resolve this?

Do you experience diarrhea? Yes No

Do you use laxatives? Yes No How often/week

Do you use enemas? Yes No How often/week

Do you leak fecal matter or stain underwear? Yes No

Do you include fiber in your diet (fruit, vegetables, bran, etc.)? Yes No

15. Previous Treatment for Incontinence

Have you done exercises (e.g. Kegels) to control urine loss? Yes No

Is so, were they helpful? Yes No

Has your doctor prescribed any medication to treat urine loss? Yes No

Have you had any surgical procedures to treat urine loss? Yes No

16. Currently

Do you experience a loss of stool... with coughing, laughing, sneezing? Always Sometimes Never

with lifting heavy objects? Always Sometimes Never

with exercising running, etc? Always Sometimes Never

when you have a strong urge to defecate? Always Sometimes Never

on the way to the toilet? Always Sometimes Never

just as getting to toilet/removing clothes? Always Sometimes Never

Do you lose stool... By continuous oozing Always Sometimes Never

In small amounts Always Sometimes Never

In moderate amounts Always Sometimes Never

In sudden large amounts Always Sometimes Never

Other, specify

Before an accident occurs do you have an urge sensation to pass your bowel? Yes No Unsure

What is the consistency of stool loss: Formed Always Sometimes Never
Hard Always Sometimes Never
Liquid Always Sometimes Never
Stringy Always Sometimes Never
Other, specify _____

Are your episodes of stool loss During the day Always Sometimes Never
At night Always Sometimes Never
Morning Always Sometimes Never
Afternoon Always Sometimes Never
Daily Always Sometimes Never
Weekly Always Sometimes Never

Is there a relationship between accidents and:
Meals Always Sometimes Never
Activity Always Sometimes Never
Flatulence/gas Always Sometimes Never
Certain foods Always Sometimes Never
If so which type of foods: _____

Did your problem begin after any of the following:
Back surgery/trauma Yes No
Brain Surgery Yes No
Bowel Surgery Yes No
Stroke Yes No
Rectal Surgery Yes No
Cancer diagnosis Yes No
Radiation Therapy Yes No
Vaginal Delivery Yes No
Episiotomy Yes No
Other, specify _____

Do you wear a pad? Always Sometimes Never
and when changing a pad are the pads...
slightly soiled Always Sometimes Never
moderately soiled Always Sometimes Never
largely soiled Always Sometimes Never

Do you... have to strain to empty you colon? Always Sometimes Never
dribble stool after your bowel movement? Always Sometimes Never
recognize leakage as it occurs? Always Sometimes Never
have pain during a bowel movement? Always Sometimes Never
how long after _____

Do you... have difficulty initiating a bowel movement? Yes No Unsure
have difficulty stopping a bowel movement? Yes No Unsure
have blood in your stool? Yes No Unsure

17. Voiding Patterns:

Voiding frequency: # of times/day _____ # of times/night _____
leakage episodes/day _____ # leakage episodes/night _____
Amount of urine when voiding ___ large ___ small ___ few drops

18. Protective Devices:

What type of protective devices do you use? (Check all that apply)

pantyliner incontinence pad sanitary pad (mini) sanitary pad (maxi)

of pads used each day? _____

Do you soak the pad full? Yes No

Do you change the pad each time it's wet? Yes No

19. Mobility/Self-Care:

Do you.....

use a cane? Yes No

use a walker? Yes No

lean on furniture for balance? Yes No

Do you have difficulty.....

with getting on/off the toilet? Yes No

getting clothes on/off? Yes No

with toilet hygiene? Yes No

20. Gynecological History (if applicable) :

of pregnancies: _____ #of vaginal deliveries: _____ length of time pushing: _____

of episiotomies: _____ # of C-sections: _____

Do you have a painful episiotomy scar ? Yes No

Do you have a history of urinary tract infections ? Yes No

Do you have a history of urine loss as a child ? Yes No

as an adolescent ? Yes No

after childbirth ? Yes No

If applicable, when was your menopause onset? _____

Have you been on Hormone Replacement Therapy? Yes No Currently? Y N

Dosage: Estrogen: _____ Type: Pills _____

Progesterone: _____ Patch _____

Cream _____

21. Surgical History: (please provide dates of all that apply to you)

_____ back/neck surgery

_____ abdominal

_____ hernias

_____ kidney surgery

_____ vaginal

_____ gall bladder surgery

_____ bladder repair

_____ ovaries removed

_____ prostate removal

_____ hysterectomy

_____ appendectomy

_____ rectal

22. Psychosocial Status:

Please list exercise, sports, hobbies or musical instruments _____

Please describe your sleeping habits (Snoring, # of hours, position, # of pillows) . _____

Are you sexually active? _____

Is there a history of sexually transmitted diseases? _____

Living arrangements: Do you live alone? Yes No

Have you had to restrict your activities due to incontinence or pain? Yes No

Have you had changes in intimate relationships/sexual functioning due to urinary incontinence or pain? Yes No

23. In your own words please describe your problem: _____

24. **Life Impairment:** What are your feelings about your problem on a scale of 1 to 10?

No Impairment 0 1 2 3 4 5 6 7 8 9 10 Severe Impairment

25. How did you hear about our clinic? _____

THANK YOU