



# Orthopedic and TMJ Physical Therapy Center

## Confidential Health Questionnaire

### Pelvic Pain

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"/> Eliminary problems     | <input type="radio"/> Pacemaker               |                                                           |
| <input type="radio"/> Falls                  | <input type="radio"/> Parkinson's Disease     | Other _____                                               |
| <input type="radio"/> Fractures              | <input type="radio"/> Polyps                  | _____                                                     |
| <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
- Urinary leaking with exercise, laughing, coughing, or on the way to the bathroom
- Clicking, popping, or pain in your jaw

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

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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
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_____	_____
_____	_____
_____	_____

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.

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Allergies: medication, food or other \_\_\_\_\_

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14. **Bowel Habits:**

How often do you have a bowel movement? \_\_\_\_\_

Are you ever constipated? Yes No

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. **Gynecological History (if applicable) :**

# of pregnancies: \_\_\_\_ #of vaginal deliveries: \_\_\_\_ length of time pushing: \_\_\_\_\_

# of episiotomies: \_\_\_\_ Do you have a painful episiotomy scar ? Yes No

# of C-sections: \_\_\_\_ 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 \_\_\_\_\_

16. **Surgery/Procedure 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
		_____ testicles

17. **Psychosocial Status:**

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

Please list exercise, sports, hobbies or musical instruments \_\_\_\_\_

\_\_\_\_\_

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

18. In your own words please describe your problem: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. **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

20. How did you hear about our clinic? \_\_\_\_\_

THANK YOU