THE GREEN ROOM
PHYSICAL THERAPY

New Patient History Form for Women's Health

Name: _____ Referred by: _____
Birthdate: _____ Primary Care Physician: _____
Occupation: _____

Please fill in the answers to the best of your ability. Your therapist will review the answers with you during your evaluation.

History of Present Condition

1. Describe your main problem: _____
_____
2. When did your symptoms begin: _____
3. Which of the following **best describes** how your condition started:

☐childbirth ☐a fall
☐after surgery ☐lifting
☐degenerative process ☐during recreation/sports
☐running ☐car accident
☐trauma ☐unknown
☐other_____

4. Since onset, are your symptoms getting: ☐better ☐worse ☐not changing 5. Which of the following best describes the nature of your symptoms? (check all that apply) ☐constant ☐ occasional

☐stabbing ☐throbbing
☐sharp ☐splitting
☐shooting ☐cramping
☐dull ☐itching
☐tender ☐hot/burning
☐aching ☐gnawing
☐n/a ☐other_____

6. Have you had any previous treatment for this condition? (check all that apply)

☐physical therapy ☐laser
☐pelvic floor exercises ☐TENS unit

☐dietary changes ☐surgery
☐electrical stimulation ☐injection into the skin/muscles ☐ biofeedback ☐ultrasound
☐joint manipulation ☐none
☐other_____

7. Describe activities you cannot do because of your problem: _____
_____
8. What are your goals for treatment? _____

Obstetrical/Gynecological History

1. Last pelvic exam (month/year): _____ 2. Last Urinalysis (month/year)_____ 3. Other special tests (specify date, type, results):_____
_____
4. Are you sexually active? ☐No ☐Yes
5. Pain or problems with sexual activity? (please describe)_____
6. Have you ever been sexually abused? ☐No ☐Yes
7. Do you have vaginal dryness? ☐No ☐Yes

8. Do you have painful periods? ☐No ☐Yes

New Patient History Form for Women's Health (1/4)

9. History of/or present sexually transmitted diseases ☐No ☐Yes, Type:_____ 10. Are you currently pregnant or attempting pregnancy? ☐No ☐Yes
11. Number of pregnancies (please include the year): _____
12. Number of Vaginal deliveries: _____ Number of Cesarean deliveries: _____ Weight of largest baby: _____
13. Episiotomies or Tearing?_____ Trouble healing after childbirth?_____
14. Complications from childbirth? _____

Bladder Symptoms

1. Do you have any of the following? (check all that apply)
   - ☐difficulty initiating a stream of urine
   - ☐no perception of bladder fullness
   - ☐weak/slow/intermittent stream of urine
   - ☐frequent toileting to avoid problems
   - ☐dribbling after stream ends
   - ☐pain/burning during urination
   - ☐blood in urine
   - ☐pain with full bladder
   - ☐n/a (skip to question #5)

2. Occurrence of incontinence or leakage:
   a. _____times per day b. _____times during the night
   c. _____times per week d. _____times per month

3. Severity of Leakage: ☐no leakage ☐few drops ☐wets underwear ☐wets outerwear ☐wets floor 4. Position or activity with leakage: (check all that apply)

   ☐no leakage ☐lying down ☐sitting

   ☐standing ☐walking ☐running

   ☐jumping ☐lifting ☐coughing

   ☐sneezing ☐laughing ☐sexual act

   ☐changing positions ☐strong urge ☐on the way to toilet

   ☐when constipated ☐other:_____ 5. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness / pressure:

   ☐never ☐occasionally/with period ☐pressure at the end of the day

   ☐pressure with straining ☐pressure with standing ☐pressure all day

6. How long can you delay the need to eliminate?

   ☐indefinitely ☐1+ hours ☐30 minutes

   ☐15 minutes ☐less than 10 minutes ☐1-2 minutes

   ☐not at all

7. Ability to stop urine flow:
   - ☐can stop completely
   - ☐can partially deflect urine stream
   - ☐unable to deflect or slow the stream

☐other: _____

8. Do you have:
   - ☐trouble emptying bladder completely
   - ☐strain/push to empty bladder
   - ☐dribble after urination
   - ☐constant urine leak
   - ☐trouble feeling bladder urge/fullness
   - ☐recurrent bladder infections

9. Fluid intake: _____8 oz glasses per day Caffeinated beverages: _____glasses per day

New Patient History Form for Women's Health (2/4)

Bowel Symptoms (only complete if you are experiencing bowel symptoms)

1. Do you have any of the following? (check all that apply)
   - ☐constipation/strain to have a bowel movement
   - ☐leak/stain feces
   - ☐have diarrhea often
   - ☐leak gas by accident
   - ☐take laxatives/enema/stool softener regularly
   - ☐include fiber in diet
   - ☐have pain with bowel movement
   - ☐n/a (skip to question #4)

2. Occurrence of bowel leakage:
   a. _____times per day b. _____times per week
   c. _____times per month d. Only with exertion or strong urge

3. Severity of bowel leakage: ☐stool staining ☐small amount in underwear ☐complete emptying 4. How often do you have a regular bowel movement? _____ per day _____ per week 5. If constipation is present, describe management techniques:_____
_____

6. Most common stool consistency: ☐liquid ☐soft ☐firm ☐pellets ☐other_____ 7. How long can you delay the need to eliminate?

   ☐Indefinitely ☐1+ hours ☐½ hour

   ☐15 minutes ☐less than 10 minutes ☐1-2 minutes
   ☐not at all

Pain (only complete if you are experiencing pain)

1. Please rate your pain 0-10 ("0" being no pain, and "10" being excruciating pain): _____
2. Area of pain: ☐back ☐leg ☐groin ☐stomach ☐other _____
3. Is the pain present when you are: ☐lying still ☐changing positions ☐both 4. What aggravates your symptoms? (check all that apply)

   ☐sitting ☐squatting ☐standing
   ☐going to/from sitting ☐sexual activity ☐lying

   ☐walking ☐menstruation ☐sustained bending
   ☐taking a deep breath ☐coughing/sneezing ☐sleeping
   ☐exercises including _____
☐repetitive activities including _____ ☐other _____ 5. What relieves your symptoms? (check all that apply)

   ☐sitting ☐heat ☐cold

☐stretching ☐rising from sitting ☐rest

☐standing ☐walking ☐exercise

☐lying down ☐massage ☐medication

☐nothing ☐other _____ 6. Does your pain wake you at night? ☐No ☐Yes

Past Medical History

1. How would you rate your general health? ☐excellent ☐good ☐average ☐fair ☐poor 2. How often do you exercise outside of normal daily activities? _____ 3. Do you smoke? ☐ No ☐Yes

4. Are you taking any medications for your current symptoms?

☐No ☐Yes List: _____ 5. P lease list any other prescription or over the counter medications you are currently taking:

_____

_____

New Patient History Form for Women's Health (3/4)

6. Have you ever been diagnosed with any of the following conditions? (check all that apply)

☐Cancer ☐Depression ☐Stroke

☐Kidney Problems ☐Thyroid Problems ☐Diabetes

☐Multiple Sclerosis ☐Arthritis ☐Head Injury

☐High blood pressure ☐Lung Problems ☐Blood Disorders

☐Epilepsy/Seizures ☐Allergies ☐Rheumatoid Arthritis

☐Osteoporosis ☐Broken Bones ☐Stomach Problems
☐Parkinson's Disease ☐Circulation/Vascular Problems

☐Heart Problems ☐Infectious Diseases (Hepatitis, Tuberculosis)

☐Other_____

7. List any past surgeries with dates of operation
Surgery: Date:

_____

_____

_____

Patient Signature: _____Date/Time: _____

Reviewed By: _____Date/Time:_____