Woodstown Physical Therapy and Sports Rehab

Are you a previous patient? ☐ Y ☐ N

Name _____ **DOB** _____ **(AGE)** _____

SS# _____ **Sex: ☐ M ☐ F**

Home Address _____ **City/State** _____ **Zip**_____

Phone (Home) _____ **Phone (Cell)** _____

Emergency Contact _____ Relationship _____ Phone_____

Your E-mail _____ Date of Injury or onset: _____

Is your injury a result of a motor vehicle accident or work related injury: _____

EMPLOYMENT/SCHOOL (Circle appropriate one)

Patient Employer/School _____ Occupation _____

Emp Address _____ City/State _____ Zip _____

Phone (Work) _____

SPOUSE'S/PARENT EMPLOYMENT (Circle appropriate one)

Spouse/Parent Name _____ Spouse/Parent Date of Birth _____

Employer _____ Occupation _____Phone_____

Employer Address_____ City/State _____ Zip _____

APPOINTMENT REMINDERS

Would you like to receive appointment reminders? If Yes, please advise how you would prefer to be reminded:

☐ Text message: (_____) _____ ☐ Email: _____

☐ Telephone Call: (_____) _____

INFORMATION RELEASE AND AUTHORIZATION

I hereby consent to the release and disclosure of my personal health information to the follow: (please list any individuals whom we have permission to discuss you care and appointments with) _____

_____

SIGNATURE: _____ Date: _____

Woodstown Physical Therapy and Sports Rehab

Medical History Questionnaire

Patient Name		Date of Birth		Age	
Height		Current Weight			
Reason for Therapy		Date of Injury or Onset			

Are you currently receiving any other care for the condition mentioned above? ☐ No ☐ Yes	If yes list:
Have you ever received therapy in the past six months for the condition mentioned above? ☐ No ☐ Yes	If so, when?
Previous Treatment Received From (check any that apply): ☐ Physician ☐ Athletic Trainer ☐ Physical Therapy ☐ Chiropractor	Previous Treatment: ☐ Successful ☐ Unsuccessful
Have you received therapy services for other problems/conditions during 2023 ☐ No ☐ Yes If yes, please list:	
Tobacco Use: ☐ No ☐ Yes If Yes, how many packs/cans a week:	
Do you now or have you ever had any of the following?	

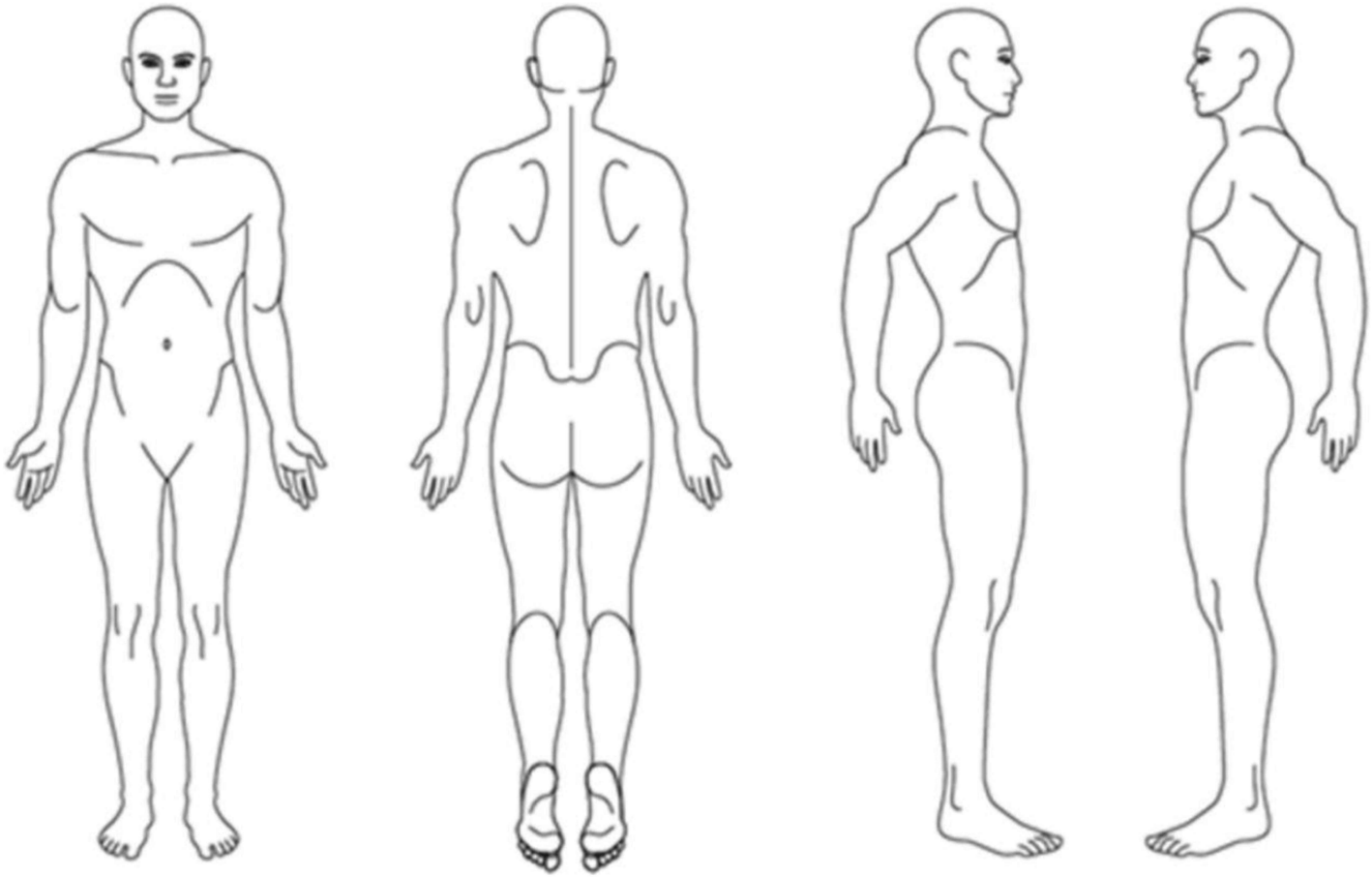
Condition	Yes	No
Arthritis	☐	☐
Osteoporosis	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Pacemaker	☐	☐
Vascular Disease	☐	☐
Stroke	☐	☐
Asthma	☐	☐
Shortness of Breath	☐	☐
Chronic Cough	☐	☐
Fainting Spells	☐	☐
Tuberculosis	☐	☐

Condition	Yes	No
Diabetes	☐	☐
Anemia	☐	☐
Hypersensitivity to Heat/cold	☐	☐
Swelling in Ankles	☐	☐
Deep Vein Thrombosis (DVT)	☐	☐
Seizures/ Epilepsy	☐	☐
Metal in Body or Surgical Implants	☐	☐
Cancer/ Tumor	☐	☐
Recent Weight Loss/ or Gain	☐	☐
Current Infection(s)	☐	☐
Hepatitis	☐	☐

Condition	Yes	No
Thyroid Problems	☐	☐
Headaches	☐	☐
Head Injury/ Concussion	☐	☐
Hernia	☐	☐
Kidney/Bladder Problems	☐	☐
Previous Fractures	☐	☐
Previous Surgeries	☐	☐
Hearing Loss	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Substance Abuse	☐	☐
Pregnant	☐	☐

Do you have any allergies? ☐ No ☐ Yes If yes, please list allergies:	
Are you presently taking any medications? ☐ No ☐ Yes If yes, please list medications and dosage/frequency:	
At the present time, would you say that your health is (circle one): Excellent Very Good Fair Poor	
The information is correct to the best of my knowledge.	
X	
Patient/Parent/ Guardian Signature	Date

Please mark an X to indicate the areas where you feel pain, swelling, numbness, or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



Patient History

Name _____ **Age** _____ **Date** _____

OB/GYN Doctor: _____

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 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:

   ___ Sitting greater than _____ minutes
   ___ Walking greater than _____minutes
   ___ Standing greater than _____ minutes
   ___ Changing positions (ie. Sit to stand)
   ___ Light activity (light housework)
   ___ Vigorous activity/exercise (run/weight life/jump)
   ___ Sexual activity
   ___ With cough/sneeze/straining
   ___ With laughing/yelling
   ___ With lifting/bending
   ___ With cold weather
   ___ With triggers –running water
   ___ With nervousness/anxiety
   ___ No activity affects the problem
   ___ Other, Please list _____
8. What relievers 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 you treatment goals/concerns? _____
    _____

Pg 2 History **Name:** _____

Since the onset of your 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: _____		

Heath History: Date of Last Physical Exam: _____ Test 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 /describe

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	Pelvic pain		
Y/N	Other /describe_____		

Page 3 Symptoms **Name**_____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Other/describe _____

Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections

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

9a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear

10b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying
__ Wets the floor

Page 4 Symptoms **Name**_____

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 _____

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

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

Over the Counter- vitamins, etc.	Start date	Reason for taking

Other Information:

_____
_____
_____
_____
_____
_____
_____

PATIENT NAME: _____ **ID#:** _____ **DATE:** _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability.

Please circle the answers below that best apply

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

Pelvic Floor Distress Inventory Questionnaire - Short Form 20

			If yes, how much does it bother you?			
			Not at all	Somewhat	Moderately	Quite a bit
1.	Do you usually experience pressure in the lower abdomen?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
2.	Do you usually experience heaviness or dullness in the lower abdomen?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
3.	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
4.	Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
5.	Do you usually experience a feeling of incomplete bladder emptying?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
6.	Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
7.	Do you feel you need to strain too hard to have a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
8.	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
9.	Do you usually lose stool beyond your control if your stool is well formed?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
10.	Do you usually lose stool beyond your control if you stool is loose or liquid?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
11.	Do you usually lose gas from the rectum beyond your control?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)

12.	Do you usually have pain when you pass your stool?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
13.	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
14.	Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
15.	Do you usually experience frequent urination?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
16.	Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
17.	Do you usually experience urine leakage related to laughing, coughing, or sneezing?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
18.	Do you usually experience small amounts of urine leakage (that is, drops)?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
19.	Do you usually experience difficulty emptying your bladder?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
20.	Do you usually experience pain of discomfort in the lower abdomen or genital region?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)

Therapist Only

ICD9 Code: _____

Comorbidities:

☐ Cancer ☐ Obesity ☐ Multiple Treatment Areas
☐ Diabetes ☐ Heart Condition ☐ Surgery for this Problem
☐ Fibromyalgia ☐ High Blood Pressure

Barber MD, Walters MD, Bump RC. Short forms of two condition-specific quality-of-life questionnaires for women with pelvic floor disorders (PFDI-20 adn PFIQ-7). Am J Obstet Gynecol 2005;193:103-113.

Depression Scale/ Self-Rated Version

Patient's Name: _____ **Date:** _____

Instructions:
Choose the best answer for how you felt over the past week.

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / NO	
2.	Have you dropped many of your activities and interests?	YES / NO	
3.	Do you feel that your life is empty?	YES / NO	
4.	Do you often get bored?	YES / NO	
5.	Are you in good spirits most of the time?	YES / NO	
6.	Are you afraid that something bad is going to happen to you?	YES / NO	
7.	Do you feel happy most of the time?	YES / NO	
8.	Do you often feel helpless?	YES / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	YES / NO	
10.	Do you feel you have more problems with memory than most people?	YES / NO	
11.	Do you think it is wonderful to be alive?	YES / NO	
12.	Do you feel pretty worthless the way you are now?	YES / NO	
13.	Do you feel full of energy?	YES / NO	
14.	Do you feel that your situation is hopeless?	YES / NO	
15.	Do you think that most people are better off than you are?	YES / NO	
		TOTAL:	

(Sheikh & Yesavage, 1986)