NEWBURY PARK
PHYSICAL THERAPY

2814 Camino Dos Rios, Suite 406
Newbury Park, CA 91320
T: 805.375.1461
F: 805.498.7613
www.nppt.com

Patient History

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

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 pain 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 (i.e., sit to stand)
- ☐ Light activity (light housework)
- ☐ Vigorous activity/exercise (run/weight lift/jump)
- ☐ Sexual activity
- ☐ Other, please list _____
- ☐ With cough/sneeze/straining
- ☐ With laughing/yelling
- ☐ With lifting/bending
- ☐ With cold weather
- ☐ With triggers (running water/key in door)
- ☐ With nervousness/anxiety
- ☐ No activity affects the problem

8. What relieves 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 your treatment goals/concerns? _____

Since the onset of your current symptoms have you had:

- ○ Y/N ○ Fever/Chills
- ○ Y/N ○ Unexplained weight change
- ○ Y/N ○ Dizziness or fainting
- ○ Y/N ○ Change in bowel or bladder functions
- ○ Y/N ○ Other /describe _____
- ○ Y/N ○ Malaise (Unexplained tiredness)
- ○ Y/N ○ Unexplained muscle weakness
- ○ Y/N ○ Night pain/sweats
- ○ Y/N ○ Numbness / Tingling

Ob/Gyn History (**females only**)

- ○ Y/N ○ Childbirth vaginal deliveries # _____
- ○ Y/N ○ Episiotomy # _____
- ○ Y/N ○ C-Section # _____
- ○ Y/N ○ Difficult childbirth # _____
- ○ Y/N ○ Prolapse or organ falling out
- ○ Y/N ○ Other /describe _____
- ○ Y/N ○ Vaginal dryness
- ○ Y/N ○ Painful periods
- ○ Y/N ○ Menopause - when? _____
- ○ Y/N ○ Painful vaginal penetration
- ○ Y/N ○ Pelvic pain

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Other /describe _____

Y/N Erectile dysfunction
Y/N Painful ejaculation

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
☐ Wets the floor

10b. How much stool do you lose?

☐ No leakage
☐ Stool staining
☐ Small amount in underwear
☐ Complete emptying

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 _____

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