kintsugi PHYSICAL THERAPY & WELLNESS	**PEVELIC FLOOR INTIAL QUESTIONAIRE AND MEDICAL HISTORY**	Name: Age: Date:

What is the reason for your visit today?	
Date of onset symptoms:	

What activities at home, work, or recreational are you unable to perform based on your symptoms?

Number of pregnancies		Number of vaginal deliveries		Number of cesarean deliveries	

Please indicate the sensations that you have been experiencing. Circle all that apply.

Did you have difficulty healing after delivery?	YES NO
Do you have a history of sexual abuse or trauma?	YES NO
In the last 4 weeks have you taken any medications for your current symptoms?	YES NO If yes, please list medications:
Please list any urological tests you have received:	

Please state if you have pain with any of the below items. If "yes", please rate your pain on a scale of 0 - 10

Sexual intercourse: YES, _____/10 NO

Pelvic Exams: YES, _____/10 NO

Tampon use: YES, _____/10 NO

Back, leg, groin, or abdominal pain: YES, _____/10 NO

Please indicate if you have any of the below bladder symptoms. Circle all that apply.

Difficulty initialing a stream	Frequent toileting to avoid problems	Strong urge to urinate
No perception of bladder fluids	Pain/burning during urination	A "falling out" feeling
Weak, slow, or intermittent stream of urine	Urinate more than 7 times/day	Blood in stool/urine
Strain to empty bladder	Dribbling after stream ends	None/NA

Please indicate if you lose urine with any the of below activities:

Cough/sneeze/laugh: YES NO

On the way to the bathroom: YES NO

When you hear running water: YES NO

Lifting/exercise/dancing/jumping: YES NO

When you have a strong urge to urinate: YES NO

Since the onset of your current symptoms, have you experienced and of the below? Circle all that apply.

Abdominal pain	Dizziness/Lightheadedness	Hear burn / indigestion	Persistent cough
Bowel/Bladder changes	Fainting	Muscle weakness	Recent infection
Difficulty swallowing	Fever/Chills/Sweats	Nausea/Vomiting	Unexplained weight loss
Difficulty walking	Headaches	Night pain	Vision changes

Are you experiencing any other pain? If yes, rate your pain on a scale of 0 – 10. 0 = no pain, 10 = Emergency	NO YES: _____/10 Location of pain: _____

PLEASE COMPLETE THE OTHER SIDE

WORK HISTORY			
Are you currently employed?	YES NO. Retired. Student		
Occupation:			
If injured on the job or with is affected by your current symptoms, please fill out the next three sections.			
Are you currently working?	YES/Full duty. YES/Light duty. NO/Last day of duty		
Are you planning to return to your job of injury?	YES NO. Unsure		
If no, has an alternate job goal been identified for you?	NO/I don't know Yes, the new goal is:		
MEDICAL HISTORY			
At the present time, would you say that your health is:	Excellent Good Fair Poor		
Please indicate if you have had any prior injuries to the following joints. Circle all that apply.			
Ankle Back Elbow Foot Hand Hip Knee Neck Shoulder			
Please indicate if you have had or currently have any of the below medical conditions. Circle all that apply.			
Allergies	Face/Ear/Jaw pain	Kidney disease	Pregnant (currently)
Anemia	Fibromyalgia	Latex of tape allergy	Rheumatoid arthritis
Asthma	Gout	Liver disease	Shortness of breath
Back/Neck pain	Heart Disease	Migraines	Skin Condition
Blood clots	Hepatitis	Multiple Sclerosis	Stroke / TIA
Cancer	Hernia	Osteoarthritis	Swelling in the feet /legs
Chest pain	Hight blood pressure	Osteoporosis	Thyroid issues
Depression	HIV+/AIDs	Pacemaker	Tuberculosis
Diabetes	Imbalance	Parkinson's	
Epilepsy / Seizures	Incontinence	Polio	
Please list and other medical conditions we should know about:			
Please list and surgeries you have had:			
Have you had any major illnesses/hospitalizations in the last year? YES NO If yes, please describe below:			
MEDICATIONS: Please list all medications you are taking including dosage, frequency, and route to administration. Include all prescriptions, over-the-counter, herbal/vitamin/mineral supplements. Please complete to the best of your ability, If you have a list, please give it to our of front office so that they may make a copy. [ ] Please see attached list. [ ] I am not taking any medications, vitamins, or supplements.			

Name	Dosage	Frequency	Route of Administration
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	

Have you had any falls in the last 12 months?		YES NO	
If yes, how many?		Did you injure yourself in any of those falls?	YES NO
Do you currently use any type of tobacco products?			

_____ _____

Patient or Guardian Signature Date

For office use only: Heart rate_____ Blood Pressure_____ Taken by:_____