PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name:_____ _____**Why are you here?**_____

Check all the Conditions that apply to you:

HEART/CIRCULATION	√	**MEDICAL PROBLEMS**	√	***CHILDBEARING HISTORY***	
Heart Disease/Surgery		Diabetes		Are you Pregnant? Yes No If yes, what is your due date:_____	
High Blood Pressure				# of Children (circle one number)	0 1 2 3 4 5 +
Pain/tightness in chest		Cancer		# of Vaginal deliveries (circle)	0 1 2 3 4 5 +
Cold Hands/feet		Dizziness		# of C-Sections (circle one number)	0 1 2 3 4 5 +
		Thyroid Problems		# of episiotomies (circle one number)	0 1 2 3 4 5 +
Numbness in hands/feet		Falls the last 6 mos.		# of forceps deliveries	0 1 2 3 4 5 +
		# trips/slips/near falls		Birth weight of largest baby	
BONES & JOINTS		Depression		***GYNECOLOGICAL HISTORY***	
Chronic Fatigue Syndrome				Date of Last Pap Smear:	
Arthritis					
Fibromyalgia		**LUNG/BREATHING**		History of Candida/Genital Herpes/ Yeast	Yes No
Tailbone pain		Shortness of Breath		Do you have any current infections or yeast	Yes No
		Smoke cigarettes now		Do you use Bath salts, vaginal sprays, deodrant	Yes No
AREAS OF PAIN		History of smoking		Do you use vaginal lubricants or ___KY jelly	Yes No
Back				Do you use latex condoms	Yes No
Neck/shoulders		**SURGICAL HISTORY**			
Rectum		Back or neck		***URINARY/BLADDER HISTORY***	
Abdomen/belly		Tubal Ligation		Do you urinate more than once every 2 hours?	Yes No
Vagina		Laproscopy		Do you have a sense of "urgency" to urinate?	Yes No
Vulvar area (around the vagina)		Abdominal Hysterectomy		Do leak urine with ___cough ___ laugh __sneeze __exercise ___lifting ____Other_____	
ALLERGIES		Vaginal Hysterectomy		Do you have interstitial cystitis	Yes No
Ragweed		Gall Bladder		How many times do you urinate at night?	1 2 3 4 5+
Food allergies		Bladder surgery		Do you trouble starting a urine stream?	Yes No
Latex allergies		Pelvic Surgery		Do you have a falling out feeling ____Yes ____No	
Seasonal Allergies		Vaginal Surgery/laser		If yes __Sometimes with menses ___Standing ___Straining ___At the end of the day ___All the time	
SKIN CONDITIONS		Vulvar Surgery		How often do you urinate during the day	
Eczema				***BOWEL HISTORY***	
Contact Dermatitis		**FAMILY HISTORY**		Do you leak gas or feces	Yes No
Psorasis		Skin cancer		Do you have constipation	Yes No
Lichens Simplex		Allergies		Is your stool __Liquid __Soft (like peanut butter) __Firm (like banana) ___Hard	
Other				How often do you have a bowel movement: __2 or more x per day __Daily __Every other day __Every 4-7 days	

LIST ALL THE MEDICATIONS YOU ARE TAKING, INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS:

Name of Medication	For what?	Name of Medication	For What?

SOCIAL, OCCUPATIONAL AND RECREATIONAL ACTIVITIES

Marital Status: __Single __Married ___Separated __Divorced ___Dating

Do you feel safe at home? ___Yes ____ No Comment:_____

Occupation:_____ Physically this means I ___sit ___stand __walk most of the day

Educational Level _____ **Hobbies**: _____ _____

EXERCISE HISTORY:
___No exercise ___Walk _____ ____Go to gym _____

Other_____

CHECK THE WORDS THAT APPLY TO HOW YOU FEEL THESE DAYS &/OR CHOOSE YOUR OWN WORDS:

DESCRIPTOR	√		√		√		√		√		√		√
Happy →		Calm →		Unmotivated		Stressed		Lonely		Content		Depressed	
Overwhelmed →		Sad →		Tired		Afraid		Energetic		Optimistic		"Postpartum blues"	
Flabby →		Strong →		Un-rested		Lethargic		Weak		Overworked		Not bonding with baby(ies)	
Anxious →		Unsafe →		Abused		Neglected							

HOW DO YOU LEARN?: ___Listening (lecture, discussion) ___Seeing (read, video, DVD) __Doing (practicing skill)

Is English your primary language? ___Yes ____No. If no, would you need a translator when you are in therapy? _____

NUTRITION: How much do you weigh? _____pounds

Would you like to ___lose or ____gain weight?	Yes No	
Have you gained/ lost more than 10 pounds in the last year?	Yes No	
Are you on any special diet?	Yes No	__Low Carb ___Atkins ___South Beach __Weight Watchers __Diabetic __Other_____
Would you say your diet is "unhealthy"?	Yes No	__too many fast foods __Not enough vegetables __High Fat __High Carb __Other_____

FLUID INTAKE: What do you drink every day?
____8 ounce glasses of water ___cans of diet soda ___cans of regular soda ___8 ounce cups of regular coffee
____8 ounce cups of decaffeinated coffee ____8-ounce cups/glasses of tea ____16-ounce cans of beer
____glasses of wine ___glasses of liquor ___ 8-ounce glasses of milk ____8-ounce glasses of juice_____
____Other_____

Anything else you would like us to know about you?_____

TELL US HOW YOUR BLADDER PROBLEM AFFECTS YOUR DAILY LIFE?

Please check the appropriate box. If any statement does not apply to you, leave that box blank.

(1) Not at all (2) Slightly (3) Moderately (4) A lot

My bladder problem :	1	2	3	4
Affects the way I dress				
Affects my ability to do my housework (cleaning, shopping, carrying)				
Affects my ability to travel more than one hour without stopping to use the bathroom				
Interferes with my social life (interrupted movies, dancing, going to worship, gatherings)				
Affects my relationship with my partner				
Affects my sex life				
Makes me feel (circle all that apply) depressed anxious embarrassed frustrated angry				
Affects my job or activities outside my home				
Affects my sleep				
Makes me worry that I smell				
Affects the amount of fluids that I drink				

Initial Score ___/44 Score at discharge ____/44

TELL US ABOUT YOUR BLADDER SYMPTOMS

There are five questions. Circle one number 0-4 that most accurately describes your symptoms:

How Often do you leak urine?	How much urine do you leak?
0 Never 1 1-4 times per month 2 2-4 times per week 3 Once per day 4 More than once per day	0 None 1 Few drops 2 Enough to soak a panty liner or underwear 3 Enough to soak a pad or wet outerwear 4 Runs down my leg or wets the floor
What type of pads/protection do you wear?	**How many pads do you use?**
0 I do not wear any pads or panty liners 1 I wear a panty liner 2 I wear mini pads 3 I wear a maxi pad 4 I wear heavy pads like Depends/Poise or diapers	0 I do not use any pads or panty liners 1 I only use pads during certain activities 2 I use 1 pad per day 3 I use 2-4 pads per day 4 I use more than 4 pads per day
How often do you get up at night to urinate?	**Activity that Causes Urine Loss**
0 0-1 time per night 1 1-2 times per night 2 3-4 times per night 3 5-6 times per night 4 More than 6 times per night	0 No activity causes leakage 1 Light Activity causes leakage 2 Moderate Activity causes leakage 3 Vigorous Activity causes leakage 4 Leak with all physical effort

Initial Score ___/20 Final Score ____/20

CURRENT SEXUAL ACTIVITY:

____Sexually Inactive due to PAIN ___Sexually inactive due to bladder problem ___Sexually active

If you are sexually active, continue with this section.

____No pain with intercourse ___Pain with intercourse, able to complete coitus __ Pain with intercourse disrupts or prevents coitus
____Pain with intercourse prevents any attempt at coitus

CHECK ALL THE ACTIVITIES THAT CAUSE OR INCREASE YOUR PAIN: _____No Pain or Pain with:

___Gynecological Examination with Speculum ___Urination after intercourse ___Finger insertion into vagina
___Tampon insertion ___Tampon removal __Partner manual stimulation __Friction with clothing __Sports activity
___Urination in general __ Wearing pads
___Other_____

CHECK THE WORDS THAT DESCRIBE YOUR PAIN: _____No Pain or Pain is:

___Hot ____Burning ___searing ___Sharp ___Tiring ___Exhausting ___frightful ___punishing ___Annoying
___Troublesome __miserable ___intense ___unbearable __discomforting ___Other_____

___ WHAT MAKES YOUR PAIN BETTER: _____NO Pain or Pain is relieved with:
____Heating pad ___Ice pack ___Resting in bed ___Resting in Chair ___ Medication ___Cream _____
____Abstaining from sexual intercourse ___Not using tampons ___Not wearing tight clothes ___other_____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ____None or:

TREATMENTS	HAS IT HELPED?	TREATMENTS	HAS IT HELPED?
Medication(s)	Yes No A little	Surgery	Yes No A little
Physical Therapy	Yes No A little	Other	Yes No A little

What started this problem? _____

Comments

_____

_____