Core Health LLC
Physical Therapy for Women
20098 Ashbrook Dr
Suite 190
Ashburn, VA 20147

Patient History

Name _____DOB_____Age_____Date_____
Address _____
Phone _____E-mail _____
Circle one: Single Married Other

1. Describe the current problem that brought you here: _____

2. When did your problem first begin? _____

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 the pain is present, rate pain on a 0-10 scale, 10 being the worst _____

Describe the nature of the pain (constant burning, intermittent ache) _____

6. Describe previous treatment or exercises for this problem _____

7. Activities/events that cause or aggravate your symptoms. Check all that apply

___ Sitting greater than _____ minutes
___ Waking greater than _____minutes
___ Standing greater than _____minutes
___ changing position (sit to stand)
___ Light activity (light housework)
___ Vigorous activity/ exercise (run/weight lift/jump)
___ Sexual activity
___other: please list

___With cough/sneeze/strain
___With laughing/yelling
___With cold weather
___With triggers (key in door)
___With nervousness/anxiety
___NO activity affects problem

8. What relieves your symptoms?

_____

_____

Sandy Guilliano PT OCS WCS
sguilliano@corehealthpt.com
www.corehealthpt.com
ph: 571 510 5968 fax: 571 386 1559

Core Health LLC
Physical Therapy for Women
20098 Ashbrook Dr
Suite 190
Ashburn, VA 20147

Patient history name: _____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
   Social activities (exclude physical activities)_____
   Diet/Fluid intake, specify _____
   Physical Activity, specify _____
   Work, specify _____
   Other _____

10. Rate the severity of this problem on a 0-10 scale (0 being no problem and 10 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	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 function	Y/N	Numbness/Tingling

Date of last physical exam _____ Tests performed _____

General Health: Excellent Good Average Fair Poor
Occupation _____ Hours/wk_____
On disability or leave? _____
Activity Restrictions? _____

Activity/Exercise none 1-2days/wk 3-4days/wk 5+days/wk
Describe _____

Mental Health Current level of stress High___ Med___ Low___
Current psych therapy? Y/N

Sandy Guilliano PT OCS WCS
sguilliano@corehealthpt.com
www.corehealthpt.com
ph: 571 510 5968 fax: 571 386 1559

Core Health LLC
Physical Therapy for Women
20098 Ashbrook Dr
Suite 190
Ashburn, VA 20147

Patient History Name: _____

Medications	Start Date	Reason for Taking

Over the counter – vitamins etc	Start Date	Reason for Taking

Have you ever had any of the following conditions or diagnoses?
Circle all that apply

Cancer
Chronic bronchitis
Asthma
Allergies (list below)
Latex Sensitivity
Hypothyroid/Hyperthyroid
Headaches
Diabetes
Arthritic conditions
Childhood bladder problems
Depression
Anorexia/bulimia
Sexually transmitted disease
Physical or Sexual abuse
Raynaud's (cold hands and feet)
Pelvic pain
Stroke
Heart problems
High Blood Pressure
Ankle swelling
Low Back pain
Sacroiliac/Tailbone pain
Alcoholism/Drug problem
Kidney disease
Stress fracture
Acid Reflux/Belching
Joint Replacement
Vision/eye problems
Hearing loss/problems
Anemia
Smoking history
Emphysema
Epilepsy/seizures
Multiple sclerosis
Head Injury
Chronic Fatigue Syndrome
Fibromyalgia
Ulcerative colitis
Irritable bowel syndrome
Hepatitis
Bone Fracture
Sports Injuries
TMJ/ neck pain
Lyme's disease

Other: Describe _____

Sandy Guilliano PT OCS WCS
sguilliano@corehealthpt.com
www.corehealthpt.com
ph: 571 510 5968 fax: 571 386 1559

Core Health LLC
Physical Therapy for Women
20098 Ashbrook Dr
Suite 190
Ashburn, VA 20147

patient history name:_____

Surgical/Procedure History

Y/N Surgery for back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your abdominal organs
Y/N Surgery for your bladder
Y/N Surgery for your bone/joints

Other/describe _____

OB/GYN History

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

Bladder/Bowel Habits/ Symptoms

Y/N Trouble initiating urine stream
Y/N Urinary intermittent/slow stream
Y/N Difficulty stopping the urine stream
Y/N Seepage/loss of BM without awareness
Y/N Trouble emptying bladder completely
Y/N Trouble holding back gas/feces
Y/N Trouble emptying bowel completely
Y/N Need to support/touch to complete BM
Y/N Trouble feeling bladder urge/fullness
Y/N Staining of underwear after BM
Y/N Constipation/straining _____% of time
Y/N Other/describe _____
Y/N Blood in stool/feces
Y/N Painful bowel movements
Y/N Trouble feeling bowel urge/fullness
Y/N Blood in urine
Y/N Dribbling after urination
Y/N Trouble controlling bowel urge
Y/N Constant urine leakage
Y/N Painful urination
Y/N Recurrent bladder infections
Y/N Current laxative use-type _____

Describe typical position for emptying _____

1. Frequency of urination: awake hours _____ times/day
sleep hours _____ times/day

Sandy Guilliano PT OCS WCS
sguilliano@corehealthpt.com
www.corehealthpt.com
ph: 571 510 5968 fax: 571 386 1559

Core Health LLC
Physical Therapy for Women
20098 Ashbrook Dr
Suite 190
Ashburn, VA 20147

2. When you have a normal urge to urinate, how long can you delay before emptying
_____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_____ other

5. The bowel movements are typically: _____watery _____loose _____formed _____pellets or other description _____
6. 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
7. If constipation is present describe management techniques _____

8. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this, how many are caffeinated? _____glasses per day.

9. Rate a feeling of organ "falling out"/prolapse or pelvic heaviness/pressure
___ None present
___ Times per month (specify if related to activity or menstrual cycle)
___With standing for _____minutes _____hours
___With exertion or straining
___Other _____

10. Bladder leakage – number of episodes ___No leakage _____Times/day _____Times/week _____Times/month ____ Only with physical exertion/cough
11. Bladder leakage – _____No leakage _____Just a few drops _____wets underwear _____Wets the floor
12. Bowel incontinence – number of episodes _____ none _____x/day _____x/month

13. How much stool do you lose? _____No leakage _____Stool staining _____Small amounts in underwear _____Complete emptying or Other _____
14. What form of protection do you wear? (please complete only one)
___None
___Minimal protection (tissue paper/paper towel/ pantishield)
___Moderate protection (absorbent product, maxi pad)
___Maximum protection (specialty product/diaper)
___ Other
15. On average, how many pad/protection changes are required in 24 hours?
_____ # of pads

Sandy Guilliano PT OCS WCS
sguilliano@corehealthpt.com
www.corehealthpt.com
ph: 571 510 5968 fax: 571 386 1559