Cynergy Physical Therapy

PATIENT INFORMATION

________________________________ ________________________________ ▫ Male ▫ Female

Last Name First Name

Name of Parent/Guardian if minor ____

____

Street Address City State Zip

__________________________ __________________________ ____

Home Phone Cellular Email Address

____ ____________________ ▫ Single ▫ Married ▫ Minor

Social Security Date of Birth

Work Status: ▫ Employed ▫ Retired ▫ Student

_____________________________________ ______________________________________ _________________

Emergency Contact Person Relationship to Person Phone

____ ______________________________

Referral Source: (Whom could we thank for referring you to our office?) Phone

____ _____________________________

Referring Physician Phone Fax: _________________________________

SIGNATURE: _____________________ DATE: ____

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Patient/Guardian ----

Relationship to Patient

PRINTED NAME:

____

PATIENT HISTORY

Name_________________________________ **Age**_______________________
Date_________________

Date of last physical exam ___________ Tests performed ___________________________

General Health: ▫ Excellent ▫ Good ▫ Average ▫Fair ▫ Poor

Mental health: Level of Stress: ▫ High ▫ Med ▫ Low Current psych therapy: ▫Yes ▫ No

Activity/Exercise: ▫ None ▫ 1-2 days/week ▫ 3-4 days/week ▫ 5+ days/week

Describe the current problem for your visit today?
____

____

When did the problem first begin? ___________________ months ago ________ years ago.

Describe previous treatment____

What degree of success have you had with your previous treatment?
____

____

Have you ever been hospitalized? ▫ Yes ▫ No

If yes, give date and explain
____

____

Surgical/Procedure History:
____

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____

Medications: ____

____

____

Allergies: (drugs, chemicals, food) ____

Are you on disability or applying for disability? ▫ YES ▫ NO

Are you involved in any litigation? ▫ YES ▫ NO

Do you wear: ▫ glasses/contacts ▫ heel lifts ▫ orthotics ▫ dental night guard

What are your treatment goals/concerns? ____

____

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

Cancer	Stress fracture	Latex sensitivity
Heart problems	Multiple sclerosis	Hypothyroid/Hyperthyroid
High Blood Pressure	TMJ problems	Diabetes
Asthma	Epilepsy/seizures	Headaches/Migraines
Tuberculosis	Head injury	Irritable Bowel Syndrome
Ankle swelling	Osteoporosis	Kidney disease
Low back pain	Fibromyalgia	HIV/AIDS
Alcoholism/Drug problems	Chronic fatigue syndrome	Hepatitis A, B, C
Depression	Rheumatoid Arthritis	Physical or Sexual abuse
Anorexia/bulimia	Osteoarthritis	Sexually transmitted disease
Smoking history	Bone fracture	Gallbladder stones
Vision/eye problems	Joint replacement	Stomach or duodenal ulcers
Hearing loss/problems	Neck pain	Persistent/recurrent indigestion
Stroke	Emphysema/Bronchitis	Bowel or intestinal trouble

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Liver trouble or jaundice
Chest pain
Shortness of breath
Birth abnormalities
Insomnia
Snoring
Rupture or hernia
Skin disease/rash
Fainting spells
Paralysis
Contact lenses
Dentures/Bridge
Hemophilia
Recent Infection
Varicose veins
Painful/difficult urination
Anemia

Pregnant/plan to start
Pelvic pain
Crohn's Disease
Pregnancy/Childbirths # ________
Bipolar disorder
Anxiety
Gout
Pacemaker/Stent/ IUD
GERD
Falls
Chills/Night sweats
Weight loss/gain
Celiac Disease
Deviated Septum
Carpal Tunnel
Sinus Problems

Constipation/Diarrhea
Memory Loss
Diastasis Recti
Incontinence
Endometriosis
Dysmenorrhea
Fibroids/Cysts
Change in Bowel/Bladder
Aneurism
Blood Clots/DVT
Arrhythmia
Food Allergy
Spondylolisthesis
Lupus
Autoimmune Disease

OBGYN History (Female only)

Childbirth vaginal deliveries #___

Episiotomy #______

C-section #________

Difficult childbirth ▫ Yes ▫ No

Prolapse ▫ Yes ▫ No

Menstrual cycle: _____ days

Vaginal dryness ▫ Yes ▫ No

Lumps in breast ▫ Yes ▫ No

Painful periods ▫ Yes ▫ No

Menopause when? __________

Painful vaginal penetration ▫ Yes ▫ No

Pelvic pain ▫ Yes ▫ No

Date of last period: ___________________

Other: ________________________________

Males only:

Prostate disorders: ▫ Yes ▫ No

Pelvic pain ▫ Yes ▫ No

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Erectile dysfunction ▫ Yes ▫ No

Painful ejaculation ▫ Yes ▫ No

Other:

____

Pain History

Since onset is it staying ▫ same ▫ getting worse ▫ getting better

Activities/events that cause or aggravate your symptoms.

Sitting

Walking

Standing

In/out bed or chair

Sexual activity

Yawning

Chewing

Swallowing

Sleeping

Cough/sneeze/straining

Laughing/yelling

Lifting/bending

Triggers such as running water/key in the door

Being nervous/anxious

No activity affects the problem

Other, specify

Type of pain:

Constant

Piercing

Aching

Dull

Sharp

Burning

Shooting throbbing

Tingling

Numbness

Superficial

Deep

Localized

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Diffused   Intermittent

Infrequent
Severity of pain:

None 1 2 3 4 5 6 7 8 9 10 worst

When is your pain or dysfunction the worst?

Morning ▫ During sleep ▫ Afternoon ▫ Upon awakening ▫ Evening ▫

Since the onset of your current symptoms have you had:

Fever/Chills ▫ Yes ▫ NO

Unexplained weight change ▫ Yes ▫ NO

Dizziness or fainting ▫ Yes ▫ NO

Change in bowel or bladder function ▫ Yes ▫ NO

Malaise (unexplained tiredness) ▫ Yes ▫ NO

Unexplained muscle weakness ▫ Yes ▫ NO

Night pain/sweats ▫ Yes ▫ NO

Numbness/Tingling ▫ Yes ▫ NO   Other/describe

____

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 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
Y/N Other/describe ________________________________

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)

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___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

Head/TMJ History

Does it hurt when you open your mouth wide? ▫ Yes ▫ NO

Does your jaw make noises so that it bothers you or others? ▫ Yes ▫ NO

Do you suffer from pain in face, jaw, eyes, throat, neck, temples? ▫ Yes ▫ NO

Do you suffer from headache? ▫ Yes ▫ NO

Do you grind your teeth in your sleep or has anyone heard you? ▫ Yes ▫ NO

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Digestive History

How long have you had abdominal pain?

____

Do you have more than one pain ▫ Yes ▫ NO

Where is the worst pain located?

____

How often the pain occur, and how long does it last?

____

Does the pain awaken you from sleep? ▫ Yes ▫ NO

Is your pain cramping, aching, burning, knifelike, or…?

____

Is there anything that alleviate the pain?

____

Does eating or drinking make pain better or worse? ▫ Yes ▫ NO

Is there any food that trigger pain or diarrhea? ▫ Yes ▫ NO

Describe your bowel movement pattern.(example, one bowel movement every two days, which is hard to pass)

____

____

____

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Has this pattern remained constant, or has it changed in recent months? ___________________________

Is your pain better after a bowel movement? ▫ Yes ▫ NO

Do you have any of the symptoms:

Bloating ▫ Yes ▫ NO Nausea ▫ Yes ▫ NO Vomiting ▫ Yes ▫ NO Belching ▫ Yes ▫ NO Gas ▫ Yes ▫ NO

Have you lost weight in recent month? If so, how much over what period of time? ▫ Yes ▫ NO

__________________________________ lbs

Have you passed blood in your stool or had black, tarry bowel movements? ▫ Yes ▫ NO

Have you previously been evaluated for these complaints? ▫ Yes ▫ NO

If yes, what tests were performed, and what were results? ____

Do you smoke? ▫ Yes ▫ NO

Do you consume alcohol? ▫ Yes ▫ NO

SIGNATURE: __________________________ DATE:_____________ ____________________________________

Relationship to Patient

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