CORE PELVIC PHYSICAL THERAPY

PATIENT HISTORY FORM

PATIENT NAME ______________________ DATE ____________

Reasons for Seeking Treatment:

1. Describe the current problem that brought you here:
2. When did this problem first begin? Please give approximate date:
3. Was your first episode related to a specific incident?
4. If pain is present, please rate your pain on a scale of 0-10 (10 being the worst):
5. Please describe the nature of your pain (constant, intermittent, burning, stabbing, shooting):
6. Since that time, is the problem: ☐ Staying the same ☐ Getting better ☐ Getting worse. Please describe why or how:

Occupation:

7. What is your current occupation?
8. Circle all that apply: Full time/Part time/ Volunteer/Retired
9. How has this problem limited daily/social/physical/work activities?
10. Amount and type of exercise per week:
11. On disability or leave? Y/N

Mental Health:

12. Current level of stress (select one): ☐ Low ☐ Medium ☐ High
13. Current psych therapy? Y/N

Symptoms:

14. Activities that cause or aggravate your symptoms.
    Please check/circle all that apply on the following page:

☐ Sitting greater than_ minutes	☐ With cough/sneeze/straining
☐ Walking greater than_ minutes	☐ With laughing/yelling
☐ Standing greater than_ minutes	☐ With lifting/bending
☐ Changing positions (i.e. sit-to-stand)	☐ With cold weather
☐ Light activity (light housework)	☐ With triggers (i.e. key in door)
☐ Vigorous activity/exercise (run/weight lift/jump)	☐ With nervousness/anxiety
☐ Sexual activity	☐ No activity affects the problem
☐ Other, please list:	

15. What, if anything, relieves your symptoms?
16. Do you have a previous history of similar symptoms?
17. Describe any previous treatment/exercises:
18. Did you have success with previous treatment? ☐ YES ☐ NO
19. Have you ever had any of the following conditions or diagnoses?

☐ Cancer	☐ Stroke	☐ Joint replacement
☐ Heart problems	☐ Epilepsy/seizures	☐ Bone fractures
☐ High blood pressure	☐ Multiple sclerosis	☐ Sports injuries
☐ Ankle swelling	☐ Head injury	☐ TMJ/neck pain
☐ Anemia	☐ Osteoporosis	☐ Emphysema
☐ Low back pain	☐ Chronic Fatigue Syndrome	☐ Chronic bronchitis
☐ Sacroiliac/Tailbone pain	☐ Fibromyalgia	☐ Asthma
☐ Alcoholism/Drug problem	☐ Arthritic conditions	☐ Latex sensitivity
☐ Childhood bladder problems	☐ Stress fracture	☐ Hepatitis
☐ Depression	☐ Acid reflux or belching	☐ Sexually transmitted disease
☐ Anorexia/bul imia	☐ Hypo/Hyper-thyroid	☐ Physical or Sexual abuse
☐ Fainting history	☐ Headaches	☐ Raynaud's (cold hands and feet)
☐ Vision/eye problems	☐ Diabetes	☐ Allergies (list below)
☐ Hearing loss/problems	☐ Kidney disease	________________________
	☐ Irritable Bowel Syndrome	________________________
	☐ Pelvic pain	________________________