Lizanne Pastore PT, MA, COMT

PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

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

Check all the Conditions that apply to you:

HEART/CIRCULATION	√	**MEDICAL PROBLEMS**	√	***URINARY/BLADDER HISTORY***	
Heart Disease/Surgery		Diabetes		Do you urinate more than once every 2 hours?	Yes No
High Blood Pressure		Melanoma		Do you have a sense of "urgency" to urinate?	Yes No
Pain/tightness in chest		Cancer		Do you have symptoms of leaking urine?	Yes No
Cold Hands		Dizziness		Do you have interstitial cystitis	Yes No
Cold Feet		Thyroid Problems		Do you have pain in your bladder?	Yes No
Numbness in hands/feet		Falls the last 6 mos.		Do you have pain with urination?	Yes No
		# trips/slips/near falls			
BONES & JOINTS		Depression			
Chronic Fatigue Syndrome		Enlarged Prostate		***BOWEL HISTORY***	
Arthritis				Do you have Irritable Bowel Syndrome	Yes No
Fibromyalgia		**LUNG/BREATHING**		Do you leak gas or feces	Yes No
Tailbone pain		Shortness of Breath		Do you have constipation	Yes No
AREAS OF PAIN		Smoke cigarettes now		Do you have pain with bowel movement	Yes No
Back		History of smoking			
Neck/shoulders					
Rectal area		**SURGICAL HISTORY**		Consistency of stool	
Abdomen/belly		Back or neck		___Hard ___Soft __liquid __pencil thin	
Penis		Gall Bladder			
Testicles		Bladder surgery			
Behind the testicle		Pelvic Surgery			
Buttocks		Pudendal Nerve Surgery			
ALLERGIES		Hemorrhoid surgery		***SEXUAL HISTORY***	
Food allergies		Prostate surgery		Do you have pain with erection?	Yes No
Latex allergies		Vasectomy		Do you have pain with ejaculation?	Yes No
Seasonal Allergies				Are you sexually active at this time?	Yes No
		FAMILY HISTORY		Are you sexually inactive due to pain?	Yes No
SKIN CONDITIONS		Skin cancer		Are you sexually inactive for other reasons?	Yes No
Eczema		Allergies			
Contact Dermatitis		Heart disease			
Psorasis		High Blood Pressure			
Other		Cancer			

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_____

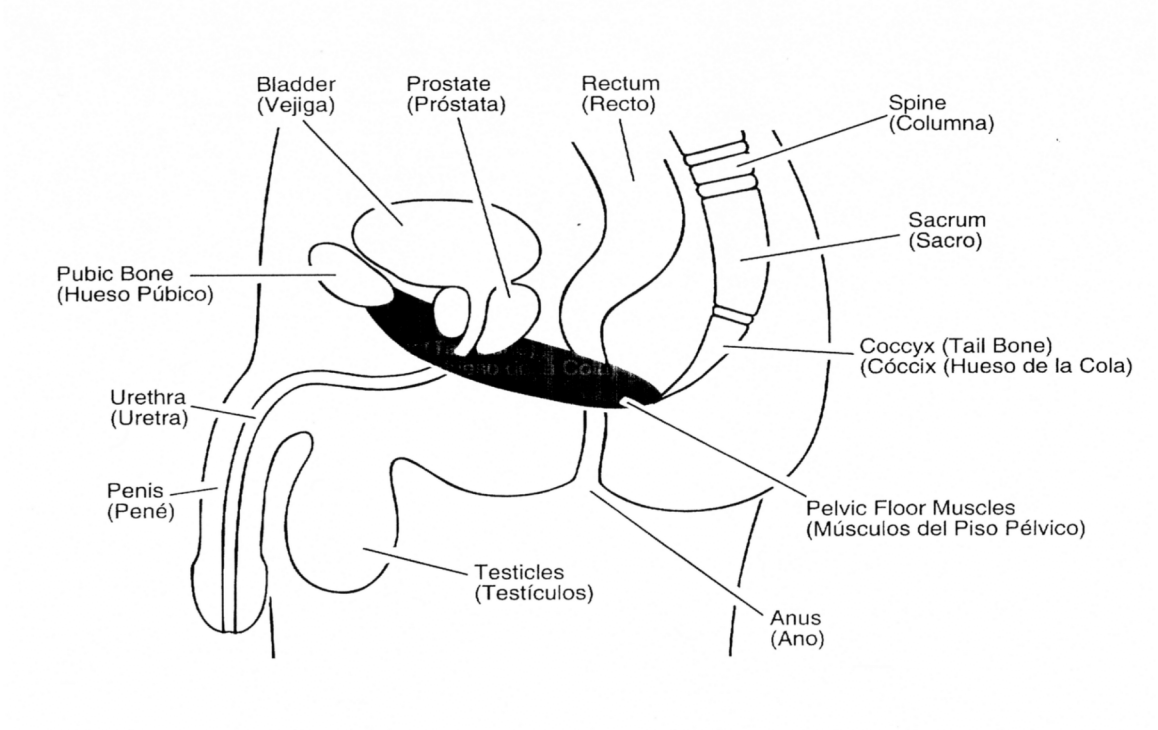
FLUID INTAKE: What do you drink every day?
____8 ounce glasses of water ___cans of diet soda ___cans of regular soda ___8 ounce cups of regular coffee
____8 ounce cups of decaffeinated coffee ____8-ounce cups/glasses of tea ____16-ounce cans of beer
____glasses of wine ___glasses of liquor ___ 8-ounce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

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

Lizanne Pastore PT, MA, COMT

TELL US ABOUT YOUR PERINEAL AND PELVIC PAIN

Please mark with an "X" where your pain begins. Shade any other areas of pain



CHECK THE WORDS THAT DESCRIBE YOUR PAIN:

___Hot ____Burning ___Scalding ___searing ___Sharp ___Cutting ___ Tearing ___Other_____
___Tiring ___Exhausting ___frightful ___punishing __grueling ___suffocating __ sickening ____Other_____
___Annoying ___Troublesome __miserable ___intense ___unbearable __discomforting ___Other_____

WHAT MAKES YOUR PAIN BETTER:

____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
Treatment for Yeast (describe treatment)	Yes No A little	Physical Therapy	Yes No A little
		Other	Yes No A little

What started this problem? _____

INDICATE THE LEVEL OF DIFFICULTY YOU HAVE WITH THE FOLLOWING ACTIVITIES USING THE KEY BELOW:
0=*No problem,* ***1***= *very small problem* ***2***=*Small problem* ***3***= *medium problem* ***4***=*Big Problem or* ***NA***

Functional/Perineal Problems	0	1	2	3	4	NA
Example: Pain with bowel movement			√			
Physician able to insert finger into the rectum for examination						
Achieve erection (with no pain or other difficulty)						
Achieve ejaculation (with no pain or other difficulty)						
Hypersensitive to touch in the perineal area						
Itching in the perineal area						
Burning/pain in the rectal area						
Burning/pain in the area of the penis or testicle						
Friction with clothing						
Pain with bowel movement						
Pain with urination						
Pain with full bladder						
Measures for Sitting						
Sitting 0- 15 minutes						
Sitting 16 – 60 minutes						
Sitting 1 -2 hours						
Sitting 2 – 4 hours						
Effect of Problem on Daily Life						
Affects choice of clothing						
Walking short distances						
Walking long distances						
Exercise in gym						
Ride a bike						
Ability to travel for work						
Ability to travel for longer than 2+ hours						
Interferes with social activity (movies, socializing)						
Interferes with my sex life						
Negatively impacts relationship with my partner						
Negatively impacts interaction with family & friends						
Feelings of ___depression ___anxiety ____embarrassment ____frustration ____anger						
Pain impairs my ability to concentrate/function						
Pain impairs my ability to work "normal" hours						