INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET
Pelvic Girdle(Page 1)

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

SUBJECTIVE

Age: _____ **When did your symptoms start?** _____
When was your last Gynecological exam: _____
Describe the current problem that brought you here: _____
_____
_____

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you had any testing? ☐ X-rays ☐ Urinalysis ☐ Post Void Residual ☐ Other
Results: _____

Have you ever had these symptoms before? ☐ Yes ☐ No **Description:** _____

Have you ever had treatment before for these symptoms? ☐ Yes ☐ No **If Yes, please describe:**

☐ **Medication:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Physical Therapy:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Other:**_____ **Beneficial?** ☐ Yes ☐ No **Explain:** _____

Did you have surgery? ☐ Yes ☐ No **Date of Surgery:** _____

If yes, what procedure did you have done? _____

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

☐ Yes ☐ No **Explain:** _____

THERAPIST COMMENTS:

CURRENT COMPLAINTS

If you have pain, what is your pain level?

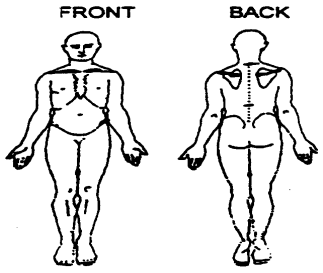
(0 = No Pain, 10 = Extreme Pain – Circle)

AT WORST: 0 1 2 3 4 5 6 7 8 9 10

AT BEST: 0 1 2 3 4 5 6 7 8 9 10

CURRENT: 0 1 2 3 4 5 6 7 8 9 10

Mark the location of your pain with an "X":



Are your symptoms: ☐ Constant ☐ Come and Go ☐ Ache ☐ Deep ☐ Superficial ☐ Dull
☐ Sharp ☐ Shooting ☐ Burning ☐ Numbness/Tingling
☐ Other: _____

Day Pattern:

Does your pain seem to be WORSE at a certain time of day? ☐ Yes ☐ No
If Yes, ☐ Morning ☐ Night ☐ Other:_____

Does your pain progress as the day goes along? ☐ Yes ☐ No
If Yes, please explain: _____

Do you have difficulty falling asleep? ☐ Yes ☐ No
If Yes, please explain: _____

Do you wake due to pain? ☐ Yes ☐ No **If Yes, # of times per night:** _____

THERAPIST COMMENTS:

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

Occupation: _____

Presently Working: ☐ Yes ☐ No **If Yes,** ☐ Full Duty ☐ Limited Duty

Restrictions: _____ **# Days Off Work:** _____

Job Duties: ☐ Sitting ☐ Computer Work ☐ Bending ☐ Heavy Lifting ☐ Traveling ☐ Standing
☐ Reaching ☐ Crawling ☐ Twisting ☐ Walking ☐ Pushing/Pulling
☐ Other: _____

Are you now, or have you ever been disabled (service or work)? ☐ Yes ☐ No **If Yes, when?** _____
If Yes, please explain: _____

What is your current living arrangement? ☐ Alone ☐ Spouse ☐ Partner ☐ Family ☐ Other: _____

Does your home have stairs? ☐ Yes ☐ No **If Yes, # of stairs:** _____

If Yes, do your stairs have handrail? ☐ Yes ☐ No **If Yes, which side going up?** ☐ Right ☐ Left ☐ Both

THERAPIST COMMENTS:

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET
Pelvic Girdle(Page 2)

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FUNCTIONAL ABILITIES AND RESTRICTIONS

What activities are difficult to perform due to your condition? □ **Squatting** □ **Sitting** □ **Standing** □ **Walking** □ **Lifting** □ **Dressing/Grooming** □ **Driving** □ **Stairs** □ **Reaching** □ **Work Tasks** □ **Kneeling** □ **Position Changes** □ **Other:** _____

What household duties are you having difficulty performing? □ **Cooking** □ **Cleaning** □ **Vacuuming** □ **Laundry** □ **Yard Work** □ **Grocery Shopping** □ **Other:** _____

Hobbies/ Interests/ Exercise: _____

What activities make your <u>symptoms</u> WORSE? _____

What activities make your <u>symptoms</u> BETTER? _____

How severe is this problem? ***(0 = Not Severe, 10 = Extremely Severe)***

How much is this problem controlling your life? ***(0= Not Controlling, 10 = Extremely Controlling)***

What were you doing previously that you are currently unable to do or are avoiding? _____

Do you use an assistive device? □ **None** □ **Cane** □ **Walker** □ **Wheelchair** □ **Other:** _____

THERAPIST COMMENTS:

PREVIOUS MEDICAL HISTORY/ MEDICAL PRECAUTIONS AND CONTRAINDICATIONS

How would you classify your general health? □ **Good** □ **Fair** □ **Poor**

In terms of your general health, please check <u>ALL</u> that apply:

□ Abdominal Pain
□ Rheumatoid Arthritis
□ Liver /Gallbladder Problems
□ Recent Fracture
□ Asthma/Breathing Difficulties
□ Sexual Dysfunction
□ **Nausea/Vomiting**
□ Heart Disease
□ **Cancer**
□ Sexually Transmitted Diseases
□ Osteoporosis
□ Pacemaker
□ HIV/AIDS
□ Hypoglycemia
□ **Unexplained Weight Loss/Gain**
□ Allergies
□ **Recent Fever**
□ **Pain with Cough/Sneeze**
□ Low Back Pain/Sciatica
□ **Recent Headaches**
□ Bladder Infections
□ Skin Abnormalities
□ **Night Pain**
□ Heart Palpitations
□ Chest Pain/ Angina
□ Depression
□ Stroke/TIA
□ Pelvic Pain
□ Polio
□ **Numbness/Tingling in Hip/Buttocks**
□ **Recent change in Bowel/Bladder Habits**
□ Kidney Problems
□ Fibromyalgia
□ Anemia
□ Seizures/Epilepsy
□ Metal Implants
□ Heart Attack
□ **Blood in Urine/Stool**
□ Smoking Habit
□ Osteoarthritis
□ Hernia
□ High Blood Pressure
□ Diabetes I or II
□ **Recent Dizziness/Fainting**
□ Other:_____

THERAPIST COMMENTS:
□ **See Attached List**

<u>SURGICAL *HISTORY*</u>

□ Surgery for Back/Spine □ Surgery for Abdominal Organs □ Surgery for Bowel □ Surgery for Female Organs
□ Surgery for Hips □ Surgery for Bladder □ Surgery for Prostate □ Other:_____

<u>OB/ GYN HISTORY</u>

□ Menopause □ Painful Periods □ Currently Pregnant: # Weeks_____ □ Episiotomy: # _____
□ Prolapse □ Painful Penetration □ Pregnancies: # _____ □ C-Sections: # _____
□ Hormone Therapy □ Vaginal Dryness □ Vaginal Deliveries: #_____

Is there any other information regarding your medical history that we should know about?

_____

_____

Patient Name: _____ Date of Birth: _____ Date of Eval: _____

BOWEL AND BLADDER HABITS

How much do you drink daily? #8 oz. Water ____#8 oz. Caffeine____#8 oz. Alcohol____#8 oz. Other_____

If you have leakage, do you leak: □ Urine □ Feces □ Gas
If Yes, # of times: Daily_____ Weekly_____ Monthly _____ If Yes, □ Minimal □ Moderate □ Severe

How often do you urinate during the day? # times: _____

How often do you urinate after going to bed? # times: _____

How often do you have a bowel movement? # times: _____ per day # times: _____per week
Consistency: □ Loose □ Normal □ Hard

Do you take your time to go to the toilet and empty your bladder? □ Yes □ No

Do you have trouble making it to the toilet on time when you have the urge? □ Yes □ No

Have you had a bladder infection in the last year? □ Yes □ No If Yes, # times _____

Have you had the feeling you have a bladder infection but did not? □ Yes □ No

Can you stop the flow of urine when on the toilet? □ Yes □ No

Do you strain to pass urine? □ Yes □ No

Do you have the sensation that you need to go to the toilet? □ Yes □ No

Do you have the feeling your bladder is still full after urinating? □ Yes □ No

Do you have a slow or hesitant urinary stream? □ Yes □ No

Do you have difficulty initiating urine stream? □ Yes □ No

Do you empty your bladder before you feel the urge to pass urine? (just in case) □ Yes □ No

Do you ignore the urge to defecate? □ Yes □ No

Do you have a history of constipation? □ Yes □ No
If Yes, do you take anything for this?_____

Do you currently strain to defecate? □ Yes □ No

How long can you delay bowel movement?
□ Not at all □ 1-2 minutes □ 3-10 minutes □ 11-30 minutes □ 31-60 minutes □ ____ hours

How long can you delay the need to urinate?
□ Not at all □ 1-2 minutes □ 3-10 minutes □ 11-30 minutes □ 31-60 minutes □ ____ hours

Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, etc.)
□ Yes □ No Explain:_____

Do your symptoms worsen with certain foods/drink? □ Yes □ No Explain: _____

Do you leak when you: □ Cough □ Sneeze □ Run □ Jump □ Walk to toilet □ During sexual activity
□ Other _____

Do you wear incontinence protection? **□ Yes □ No**
If Yes, # used per day: □ Pantishield_____ □ Minipads_____ □ Maxipad_____
□ Other_____

THERAPIST COMMENTS:

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking (including over-the-counter, prescriptions, herbals, and vitamins/minerals):

_____

_____

THERAPIST COMMENTS:
□ See Attached List

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? _____

_____

THERAPIST COMMENTS:

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ Date: _____
Therapist's Signature: _____ License #: _____ Date:_____
Printed Therapist's Name: _____