# Kerry Becht Physical Therapy and Massage

## MEDICAL HISTORY AND STATUS QUESTIONNAIRE

Name: _____ Date of Birth: _____

Referred by: _____ Employer: _____

Occupation: _____ Marital Status: _____

Reason for referral to physical therapy: _____

In case of emergency notify (name and number): _____

**Please check all medical problems that you now or have had in the past:**

| | | |
|---|---|---|
| _____ Back pain | _____ Pelvic/vulvar pain | _____ Rectal Pain |
| _____ Shoulder/elbow/wrist pain | _____ Ankle/foot pain | _____ Diabetes |
| _____ Knee pain | _____ Carpal Tunnel Syndrome | _____ Arthritis |
| _____ Pain with intercourse | _____ Chronic Fatigue Syndrome | _____ Fibroids |
| _____ Leg cramps | _____ Endometriosis | _____ Osteoporosis |
| _____ Interstitial cystitis | _____ Light-headedness | _____ Kidney disease |
| _____ Pelvic inflammatory disease | _____ Cancer _____ | _____ Headaches |
| _____ Sexually transmitted disease | _____ Heart/lung problems | _____ TMJ pain |
| _____ Epilepsy | _____ Unusual reaction to heat/cold | _____ Hip pain |
| _____ Broken bones/fractures | _____ Smoking packs/day _____ | _____ Neck pain |
| _____ Urinary incontinence | _____ Fecal incontinence | _____ Bowel problem |

**Please list your usual recreational/exercise activities and frequency:** _____

_____

**Please check all previous surgeries/testing and list dates:**

| | | | |
|---|---|---|---|
| _____ Hysterectomy: _____Abdominal _____Vaginal _____Ovaries removed? | | | Date: _____ |
| _____ Hernia repair | Date: _____ | _____ C-Section | Date: _____ |
| _____ Appendectomy | Date: _____ | _____ Kidney surgery | Date: _____ |
| _____ Gallbladder | Date: _____ | _____ Bladder repair | Date: _____ |
| _____ Back Surgery | Date: _____ | _____ Neck surgery | Date: _____ |
| _____ Prostate | Date: _____ | _____ Urodynamics | Date: _____ |

Other surgeries/tests and dates (MRI, CT scan, X-rays, etc): _____

_____

**Please list all prescription and non-prescription medications:** _____

_____

_____

**Hormone replacement therapy?:** Yes No

_____ Pilll _____ Patch _____ Cream _____ Estrogen _____ Progesterone

**Women Only – Obstetric History:** How many children do you have: _____

If pregnant, due date: _____ # weeks gestation: _____ # previous pregnancies: _____

# vaginal deliveries: _____ # C-sections: _____ # episiotomies: _____

Painful episiotomy scar? ____ Other painful incisions? _____

Complications this or prior pregnancies: _____

Level of exercise prior to pregnancy: _____

Level of exercise now: _____

Limitations to normal activities: _____

**Bladder Habits – Please check all that apply:**

_____ Frequent urinary tract infections

_____ Strong urge to urinate produces involuntary loss

_____ Loss of urine on the way to the bathroom

_____ Urgency when you are cold or hear running water

_____ Loss of urine with cough, sneeze, lifting, exercise, running, straining

_____ Difficulty initiating urine stream

_____ Loss of urine upon arriving at the bathroom

_____ Difficulty stopping urination

_____ Pain with urination

_____ Blood in urine

# voids/day: _____ # voids/night: _____ #episodes involuntary urine loss/day: _____

Amount lost: _____small _____large _____few drips _____continuous dribbling

Bed wetting? Y or N Do you use protective devices? Y or N # pads/day: _____

Do you restrict fluid intake because of urinary leakage? Y or N

# Caffeinated and/or carbonated beverages/day: _____

# Cups of water/day: _____ # Cups of juice/day: _____

Have you ever taken prescription medication(s) to prevent urine loss? _____

**Bowel Habits:**

Do you have any gastrointestinal disease? Y or N _____

Are you frequently constipated? Y or N

How do you resolve this? _____High fiber diet _____Laxatives _____Enemas

Do you have diarrhea? Y or N

Do you notice blood in your stool? Y or N Often? Y or N Hemorrhoids? Y or N

Do you have rectal pain? Y or N

If yes: _____At rest _____Sharp, fleeting pain _____With bowel movement

Any loss of stool during activity, strain, or post voiding dribbling? Y or N Amount:_____

**Please rate your pain level on a scale of 1-10**

Pain free 0 1 2 3 4 5 6 7 8 9 10 Severe

Where is your pain? _____

**Please rate how your pain interferes with the quality of your life:**

Doesn't interfere 0 1 2 3 4 5 6 7 8 9 10 Disabling

Patient attestation: I have completed this medical history form out to the best of my ability. I will inform my therapist of any changes in medical history, health status, and medication changes during the course of my physical therapy.

_____ _____ _____

Printed Patient Name Patient Signature Date