

# JOINT EFFORT MANUAL PHYSICAL THERAPY

*Specializing in Women's Health and Orthopedics*

## Patient Questionnaire

Name \_\_\_\_\_  
Home address \_\_\_\_\_  
City/state/zip \_\_\_\_\_  
Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell: \_\_\_\_\_

Physician \_\_\_\_\_  
Address \_\_\_\_\_  
City/state/zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

Circle your preferred contact method:    home            work            cell

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Profession \_\_\_\_\_

### Chief Complaints

Chief Complaint: \_\_\_\_\_

Onset of Symptoms: \_\_\_\_\_

Causes of Symptoms: \_\_\_\_\_

List all diagnostic tests with findings: \_\_\_\_\_

Are you experiencing any pain? Yes / No. Where? \_\_\_\_\_

Are you experiencing any loss of sensation? Yes / No. Where? \_\_\_\_\_

Are you experiencing any weakness? Yes / No. Where? \_\_\_\_\_

Are you experiencing tingling or pins & needles sensation? Yes / No. Where? \_\_\_\_\_

Change in bladder or bowel habits? Yes / No. Describe \_\_\_\_\_

Other? \_\_\_\_\_

### Describe Your Pain

Where is the pain located? \_\_\_\_\_

Since onset, the pain has *increased / decreased / stayed the same*.

Has the pain spread? Yes / No If yes, where? \_\_\_\_\_

Describe your pain/symptom: (check all that apply)

- |                                    |                                    |                                   |                                  |                                   |
|------------------------------------|------------------------------------|-----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> constant  | <input type="checkbox"/> periodic  | <input type="checkbox"/> sharp    | <input type="checkbox"/> dull    | <input type="checkbox"/> pressure |
| <input type="checkbox"/> throbbing | <input type="checkbox"/> deep ache | <input type="checkbox"/> heavy    | <input type="checkbox"/> burning | <input type="checkbox"/> heavy    |
| <input type="checkbox"/> burning   | <input type="checkbox"/> tingling  | <input type="checkbox"/> shooting |                                  |                                   |

Pain increases with: \_\_\_\_\_

Pain decreases with: \_\_\_\_\_

What activities do your symptoms interfere or prevent you from doing? \_\_\_\_\_

Please rate your pain level from 0 – 10 (0 = no pain, 10 = worst pain): \_\_\_\_\_

## Medical History

**Do you have or have you ever had ANY of the following?**

Asthma, Bronchitis, Emphysema	Yes / No	Coronary Artery Disease or Angina	Yes / No
Epilepsy / Seizures	Yes / No	Pacemaker	Yes / No
High Blood Pressure	Yes / No	Heart Attack or Surgery	Yes / No
Stroke / TIA	Yes / No	Anemia	Yes/ No
Thyroid Disease or Goiter	Yes / No	Neurological Disorder	Yes / No
Diabetes	Yes / No	Cancer	Yes / No
Arthritis	Yes / No	Osteoporosis	Yes / No
Gout	Yes / No	Mental Disorders	Yes / No
Chronic Headaches	Yes / No	Hernia	Yes / No
Bladder Infection	Yes / No	Interstitial Cystitis	Yes / No
Joint Replacement surgery	Yes / No	Unexplained weight loss	Yes / No
Kidney Infection	Yes / No	Kidney Stones	Yes / No
Pelvic or Abdominal Adhesions	Yes / No	Hormonal Problems	Yes / No
Pelvic Pain	Yes / No	Abdominal Pain	Yes / No
Constipation	Yes / No	Digestive Problems	Yes / No
Intestinal Problems	Yes / No	Hemorrhoids	Yes / No
Chronic Fatigue	Yes / No	Urinary Incontinence	Yes / No
Spinal Surgery	Yes / No	Abdominal Surgery	Yes / No

**Please provide any additional information:** \_\_\_\_\_

**Do you drink alcohol? Yes / No How many drinks per week?** \_\_\_\_\_

**Do you smoke cigarettes? Yes/ No How many per week?** \_\_\_\_\_

**How many cups of caffeinated drinks do you drink daily?** 0, 1-2, 3-4, 5-6, Over 6

**How often do you exercise? \_\_\_\_\_ What exercises?** \_\_\_\_\_

## Medication List

**Please list all medication** (prescribed, over the counter, vitamins, etc).

Name/Dosage	Frequency	Name/Dosage	Frequency

*Joint Effort Manual Physical Therapy*

**FEMALES ONLY**

**Medical History**

**Do you have or have you ever had ANY of the following?**

Cysts	Yes / No	Uterine Fibroids	Yes / No
Endometriosis	Yes / No	Vaginal Infection	Yes / No
Pelvic Inflammatory Disease	Yes / No	Painful Intercourse	Yes / No
STD or Herpes	Yes / No	Vaginal Dryness	Yes / No

**Surgical History**

**(Please provide the approximate date or check no)**

<b>Surgery</b>	Yes/Date	No	<b>Surgery</b>	Yes/Date	No
Pelvic Surgery			Adhesion Removal		
Fibroids Removed			Abdominal Surgery		
Laparoscopy			Laparotomy		
Appendectomy			Episiotomy		
Surgery to the Cervix			Hysterectomy (total/partial)		
Bladder Repair			Other:		

**Menstruation and Pregnancy History**

**Date of your most recent pelvic exam?** \_\_\_\_\_

**What form of birth control do you use?** \_\_\_\_\_

**Date of your last period?** \_\_\_\_\_

**Menstruation History:**

How often do you have a period (in days)? ..... every \_\_\_\_\_ days

On average, how long does your period last (in days)? ..... \_\_\_\_\_

Do you ever experience severe pain with your periods? ..... Yes / No

If yes, do you need medication? ..... Yes / No

What other symptoms do you experience with your period? \_\_\_\_\_

**Pregnancy History:**

How many pregnancies have you had? ..... \_\_\_\_\_

How many were full term? ..... \_\_\_\_\_

Birth weight each baby 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

How many tubal pregnancies (ectopics)? ..... \_\_\_\_\_

Have you had any miscarriages? Yes / No

Have you had any abortions? Yes / No

Have you ever been told that you are infertile? Yes / No

Are you undergoing any treatment for infertility? Yes / No

**Labor & Delivery History:**

Please list any complications with labor & delivery \_\_\_\_\_

Did you have an episiotomy? ..... Yes / No

Did you have a C-section? ..... Yes / No

## INFERTILE WOMEN ONLY

### Please answer to the best of your knowledge

How long have you had unprotected intercourse, without a full-term pregnancy? \_\_\_\_\_

On average, how often do you have sexual intercourse per week? \_\_\_\_\_

Do you know when you are ovulating? .....never / sometimes / frequently / always

Ovulation is confirmed by? ..... Basal body temperature / home ovulation test / ultrasound / progesterone levels / other \_\_\_\_\_

Has your partner had a semen analysis? Yes / No

Sperm count: Normal / Abnormal Sperm motility: Normal / Abnormal

### Please identify any infertility treatments you have had:

**Clomid** \_\_\_\_\_ times. Dates \_\_\_\_\_ successful / unsuccessful / mixed

**Hormone treatment** \_\_\_\_\_ months. Dates \_\_\_\_\_ successful / unsuccessful / mixed

**Intrauterine Insemination** \_\_\_\_\_ times. Dates \_\_\_\_\_ successful / unsuccessful / mixed

**Surgery to open tubes** \_\_\_\_\_ times. Dates \_\_\_\_\_ successful / unsuccessful / mixed

**In vitro fertilization** \_\_\_\_\_ times. Dates \_\_\_\_\_ successful / unsuccessful / mixed

Are you presently undergoing any treatment for infertility? Yes / No What? \_\_\_\_\_

Have you ever been told you have pelvic adhesions? .....Yes / No / Unsure

How did your physician diagnose the adhesions? .....HSG / laparoscopy / Unsure

Were you treated for adhesions? Yes / No / Unsure. How? \_\_\_\_\_

Have you ever been told you have endometriosis? .....Yes / No / Unsure

How did your physician diagnose the adhesions? .....HSG / laparoscopy / Unsure

Have you been treated for endometriosis? Yes / No / Unsure. How? \_\_\_\_\_

Have you ever been told you had pelvic inflammatory disease? .....Yes / No / Unsure

How did your physician diagnose the adhesions? .....HSG / laparoscopy / Unsure

Have you been treated for PID? Yes / No / Unsure. How? \_\_\_\_\_

### Reproductive system: (Circle all appropriate choices)

**Fallopian Tubes: Left:** functional / adhered / impaired / removed / unsure

**Right:** functional / adhered / impaired / removed / unsure

Describe: \_\_\_\_\_

**Ovaries: Left:** functional / adhered / impaired / removed / unsure

**Right:** functional / adhered / impaired / removed / unsure

Describe: \_\_\_\_\_

**Fimbriae: Left:** functional / adhered / impaired / removed / unsure

**Right:** functional / adhered / impaired / removed / unsure

Describe: \_\_\_\_\_