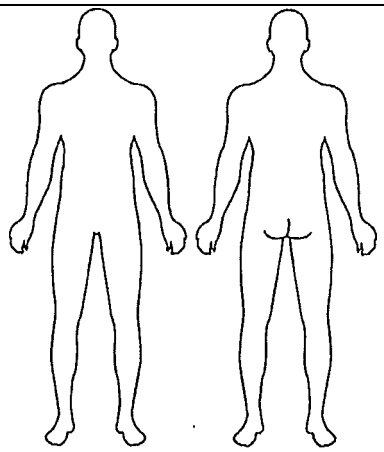
Oakdale OB/GYN

Physical Therapy Patient Questionnaire

Name: _____ Date: _____ DOB:_____

Age: _____ Height:_____ Weight:_____

What are your symptoms:
Indicate areas of pain or abnormal sensation on the body chart below (shade in where appropriate)



Front **Back**

When did your symptoms begin? (Please indicate a specific date if possible)
On a scale from 1-10 please indicate your level of pain? **(0 begin "no pain" and 10 being "worst pain imaginable")**
Was the onset of this episode gradual or sudden? (please select one) □ Gradual □ Sudden
What is the cause of your symptoms?
Are you currently pregnant? □ NO □YES, how many weeks _____
Are you currently breastfeeding? □ NO □YES
Nature of pain/symptoms (check all that apply) □ sharp □ aching □ constant □ dull □ periodic □ throbbing □ occasional □other_____
As the day progresses, do your symptoms: (check one) □ increase □ decrease □ stay the same
Does the pain wake you at night? □ NO □ YES, how many times a night do you wake**:**_____
Since the onset of your current symptoms have you had: □ any difficulty with control of bowel or bladder function □ fever/chills □ any numbness in the genital or anal area □ numbness □ any dizziness or fainting attacks □ weakness □ unexplained weight changes □ night pain/sweats □ malaise (vague feeling of bodily discomfort) □ problems with vision/hearing □ none of the above

What aggravates your symptoms? (check all that apply)

□ going to/rising from sitting
□ up/down stairs
□ reaching in front of body
□ reaching across body
□ getting in/out of car
□ lying down
□ dressing lower body
□ coughing/sneezing
□ looking overhead
□ sustained bending
□ household activities
□ reaching overhead
□ reaching behind back
□ getting in/out of bed
□ repetitive activities
□ squatting
□ dressing upper body
□ taking a deep breath
□ stress
□ other _____

What relieves your symptoms? (check all that apply)

□ sitting □ rest □ massage □ heat □ standing
□ medication □ cold □ walking □ nothing □ stretching
□ exercise □ lying down □ wearing a splint/orthosis
□ other:_____

Have you had any previous treatment for this condition? (check all that apply)

□ none □ physical therapy □ medication (oral)
□ hypnosis □ joint manipulation □ biofeedback
□ exercise □ TENS unit □ massage therapy
□ acupuncture □ traction □ bed rest
□ bracing/taping □ overnight hospitalization □ injection into spine
□ casting □ injection into skin/muscles
□ other:_____

Have you had any of the following tests?

□ none □ Arthrogram □ TENS unit
□ x-ray □ Vestibular □ biofeedback
□ CT scan □ Bone scan □ MRI
□ Stress x-ray
□ other:_____
□ Test Results:_____

How long can you tolerate each of the following activates?

Sitting**:**_____ Standing**:**_____
Walking**:**_____ Light Housework**:**_____

Work History:

Occupation**:**_____
□ employed full-time □ employed part-time □ self employed
□ homemaker □ student □ retired
□ unemployed □ other_____

Physical activities at work (check all that apply)

□ sitting □ standing □ phone use □ repetitive lifting □ computer use □ driving
□ heavy lifting □ other_____

Are you currently receiving or seeking diability for this condition? □ NO □ YES

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

□ NO □ YES

Living Situation:
□ live alone □ live with family members □ live with caregiver □ retirement complex
□ home/apartment □ assisted living complex □ other:_____
Setting:
□ stairs (railing) □ no stairs □ stairs (no railing) □ ramp □ elevator □other_____

Have you fallen in the last year? If so, what were the circumstances?

How would you rate your average health?
□Excellent □ Average □ Good □ Fair □ Poor

Do you use exercise outside of normal daily activities?
□ 5+ days/wk □ 3-4 days/wk □ 1-2 days/wk □ occasionally □ zero

Recreation activities consisting of:
□ running □ golfing □ walking □ biking □ tennis □ skiing □ swimming
□ other:_____

Do you drink caffeinated beverage?
□ NO □ YES How many/much per day:_____

Do you smoke?
□ NO □ YES Packs of cigarettes per day:_____

What is your stress level:
□ low □ medium □ high

Are you seeing any heath care providers other than the physical therapist of the current condition? (please list):

Past Medical History (Have you ever had/been diagnosed with any of the following, check all that apply)

□ Cancer (type)_____	□ Heart problems	□ Depression
□ High blood pressure	□ Stroke	□ Lung problems
□ Kidney problems	□ Blood disorders	□Thyroid problems
□ Epilepsy/seizures	□ Diabetes	□ Allergies
□ Multiple sclerosis	□ Rheumatoid arthritis	□ Arthritis
□ Osteoporosis	□ Head injury	□ Broken bone
□ Stomach problems	□ Circulation/vascular problems	□ Parkinson's disease

□ Infectious disease (i.e. hepatitis, Tuberculosis, etc
□ Other:_____

Please list any past surgeries related to your current problem: (include surgery and date)

What are your goals for physical therapy?

Bladder Symptoms: □ NO □ YES (please check all that apply below)

□ Leaking with coughing/sneezing

□ Urinary urgency, list triggers:_____

□ Leaking with urgency

□ Urinary frequency, list number of times urinating during the day _____, at night _____

□ Pain with full bladder

□ Pain with urination

□ Unable to fully empty your bladder

Bowel Symptoms: □ NO □ YES (please check all that apply below)

□ Bowel incontinence

□ Bowel urgency

□ Constipation

□ Straining to have a BM

How many BMs do you have per day?_____ How many BMs do you have per week?_____

Describe the consistency of stool? _____

Sexual Function:

Do you have pain with vaginal penetration? □ NO □ YES

Oswestry Disability Index 2.1a

Patient Label
(Office Use Only)

First Name

Last Name

Date of Birth (mm/dd/yyyy)

Today's Date (mm/dd/yyyy)

Office Use Only

Could you please complete this questionnaire? It is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer ***every section.*** Fill in the ***one bubble only*** in each section that most closely describes you ***today.***

Section 1 - Pain intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 - Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than one mile.
- Pain prevents me walking more than a quarter of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- I can sit in any chair as long as I like.
- I can sit in my favourite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting for more than half an hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 - Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than half an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 - Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours of sleep.
- Because of pain I have less than 4 hours of sleep.
- Because of pain I have less than 2 hours of sleep.
- Pain prevents me from sleeping at all.

Section 8 - Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 - Social life

- My social life is normal and causes me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport,etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

Section 10 - Travelling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from travelling except to receive treatment.

33655

References:
Fairbank JC, Pynsent PB. "The Oswestry Disability Index" Spine 2000; 25(22): 2940-2952
Fairbank JC, Couper J, Davies JB. "The Oswestry Low Back Pain Questionnaire" Physiotherapy 1980: 66: 271-273

Female NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

Center for Urologic and Pelvic Pain

Name: _____
Date: _____

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

	Yes	No
a. Area between rectum and vagina (perineum)	1	0
b. Labia	1	0
c. Clitoris (not related to urination)	1	0
d. Below your waist in your pubic area	1	0
e. Below your waist in your rectal area	1	0

2. In the last week, have you experienced:

	Yes	No
a. Pain or burning during urination?	1	0
b. Pain or discomfort during or after sexual climax?	1	0

3. How often have you had pain or discomfort in any of these areas over the last week?

0 Never
1 Rarely
2 Sometimes
3 Often
4 Usually
5 Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

0 Not at all
1 Less than 1 time in 5
2 Less than half the time
3 About half the time
4 More than half the time
5 Almost always or always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

0 Not at all
1 Less than 1 time in 5
2 Less than half the time
3 About half the time
4 More than half the time
5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

0 None
1 Only a little
2 Some
3 A lot

8. How much did you think about your symptoms, over the last week?

0 None
1 Only a little
2 Some
3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

0 Delighted
1 Pleased
2 Mostly satisfied
3 Mixed (about equally satisfied and dissatisfied)
4 Mostly dissatisfied
5 Unhappy
6 Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c, 1d, 1e, 2a, 2b, 3, and 4 =____
Urinary Symptoms: Total of items 5 and 6 =____
Quality of Life Impact: Total of items 7, 8, and 9 =____

Adapted from Litwin et al. J Urol. 1999;162:369-375