Core Dynamics Physical Therapy

308 WILLOW AVENUE HOBOKEN, NJ 07030 ● Ph: 201-568-5060● FAX 201-568-5061

WOMEN'S HEALTH PHYSICAL THERAPY QUESTIONNAIRE

NAME: _____ **DATE:** _____

Answering the following questions will help us to manage your care better.

What is the reason for your visit? :_____

_____

When did this start? :_____

Do you currently have or have you had a history of any of the following?

____	Bladder infections	____	Pelvic Pain	____	Heart Problems
____	Painful intercourse	____	Constipation	____	High Blood Pressure
____	Low back pain	____	Joint Replacement		
____	Diabetes	____	Abdominal pain		
____	Multiple sclerosis	____	Stroke		
____	Asthma	____	Heart Disease		
____	Allergies	____	Emphysema/bronchitis		
____	Menopause	____	Smoking habit		
_____	Epilepsy	____	Fibromyalgia		
____	Cancer	____	Osteoporosis		
____	TMJ	____	Sexually transmitted disease		
____	Thyroid Problems	____	Headaches		
____	Other_____				

Have You Ever Been Pregnant? (Please List Number, Date and Delivery Method Below)

_____

_____

_____

Did you have an Episiotomy? Tearing and stitching? _____

Please list any past surgical procedures: _____

_____

_____

Please list any current medications (prescription and over the counter), for what reason:

_____

_____

_____

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What is your work status? Is physical activity required in this position? _____
_____

Do you exercise? Please give description: _____
_____

What aggravates your symptoms: _____
_____

Eases?:_____

What are your functional limitations/What do your symptoms limit you from?_____
_____

	Always	Sometimes	Never
1. Do you have trouble making it to the toilet in time?	_____	_____	_____
2. Do you lose urine when you have a strong urge to urinate?	_____	_____	_____
3. Do you lose urine with any of the following?			
Coughing or sneezing:	_____	_____	_____
Laughing:	_____	_____	_____
Lifting:	_____	_____	_____
Active exercise (running, etc):	_____	_____	_____
Minimal exercise (walking, light housework):	_____	_____	_____
Sleeping:	_____	_____	_____
Nervousness/increased anxiety:	_____	_____	_____
Leakage unrelated to any specific cause:	_____	_____	_____
Other:	_____	_____	_____
	_____	_____	_____

4. Do you experience leakage: Never___, 1/week___, 2-3/week___, 1/month___,>1/day_____
5. Amount of Leakage: None___, Small Amount___, Moderate Amount___, Large Amount_____
6. Do you use sanitary pads?___, tissue paper___, diapers___
7. How many pads per day?___
8. How often do you urinate during the day?_____
9. How often do you urinate at night?_____
10. Is the volume of urine you usually pass? Large___, Average____, Small_____, Very Small_____
11. Do you experience any of the following Voiding Symptoms? Incomplete Emptying _____, Hesitancy_____, Slow Stream_____, Intermittent Stream_____
12. Do you urinate frequently, before you experience the urge, just so you can stay dry? Yes_____ No_____
13. How many glasses of fluid do you drink per day? _____
14. How many beverages are caffeinated? _____

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15. Do you experience any bowel or gas control problems? Please explain:
    _____
    _____
16. Do you experience Fecal Incontinence? _____ How Often?_____
17. Do you experience a feeling of "falling out" or pelvic pressure? _____

Pelvic floor dysfunctions can be very distressing to people. Whether you experience urinary incontinence, fecal incontinence, pelvic floor pain, painful intercourse, or urinary frequency, these issues are frequently not discussed openly with family, friends or one's healthcare providers.

In order to fully understand the scope of your individual diagnosis, there are some very important questions that must be answered. You may be brief in your response. If your therapist needs you to expand upon your answers, she will ask you privately.

1. Are you currently sexually active? Yes No

   If "no", have you been sexually active in the past? Yes No
2. Do you have any communicable diseases? Yes No
3. Do you experience/have you experienced painful intercourse (Dyspareunia)?

   Yes No
4. During a Gynecological Exam, do you experience pain with the Speculum?

   Yes No
5. Has there been any sexual abuse in your past? Yes No