

Core Dynamics Physical Therapy

200 ENGLE STREET, SUITE 20 ENGLEWOOD, NJ 07631 • 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?

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