**When did this concern start?**

**Can you please describe your concern(s)?**

**Are you currently seeing a health care provider and why?**

**Have you seen anyone about your current complaint and who?**

***DIAGNOSTICS:* Have you had any diagnostic testing or imaging done for this concern?**

|  |  |
| --- | --- |
| **Diagnostic Test** | **Date** |
| Radiographs (X-Rays) |  |
| MRI |  |
| Ultrasound |  |
| CT Scan |  |
| Blood Work |  |
| Urinalysis |  |
| Urodynamics |  |
| Cystoscopy |  |
| Colonoscopy |  |
| Endoscopy |  |

***MEDICAL SCREEN*: Please indicate if you presently have, or have had, any of the following. Please provide relevant details.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition/Symptom** | **√ if Yes** | **Details** | **Condition/Symptom** | **√ if Yes** | **Details** |
| Heart Problems/Chest Pain |  |  | Epilepsy/Seizures |  |  |
| Pacemaker |  |  | Numbness/Tingling |  |  |
| High Blood Pressure |  |  | Loss of Sensation |  |  |
| High Cholesterol |  |  | Dizziness/Vertigo |  |  |
| TIA/Stroke |  |  | Muscular Weakness |  |  |
| Chronic Cough |  |  | Headaches |  |  |
| Lung/Breathing Difficulties |  |  | Fainting Spells |  |  |
| Skin Disease/Sensitivity |  |  | Depression/Anxiety |  |  |
| Open Sores/Skin Lesions |  |  | Mental Health Disorder |  |  |
| Trouble Seeing |  |  | Diabetes |  |  |
| Trouble Hearing |  |  | Thyroid Dysfunction |  |  |
| Low Back Concerns. Chronic? |  |  | Poor Sleep/Insomnia |  |  |
| Mid Back Concerns. Chronic? |  |  | Hours of sleep per night? |  |  |
| Neck Concerns. Chronic? |  |  | Night Pain |  |  |
| Osteoporosis |  |  | Fever/Chills |  |  |
| Osteopenia |  |  | Fibromyalgia |  |  |
| Broken Bones/Fractures |  |  | Chronic Fatigue |  |  |
| Arthritis |  |  | Anemia |  |  |
| HIV/AIDS/Hepatitis |  |  | Nutrient Deficiency |  |  |
| MRSA/VRE |  |  | Kidney Disease/Stones |  |  |
| Rheumatic Fever/Polio |  |  | Blood In Urine? |  |  |
| Tuberculosis |  |  | Crohn's Disease |  |  |
| Repeated Infections |  |  | Celiac Disease |  |  |
| Cancer (Where/When?) |  |  | IBS |  |  |
| Unplanned Weight Change |  |  | Ulcerative Colitis |  |  |
| Nausea/Vomiting |  |  | Allergies |  |
| Food Sensitivities |  |  |

***SURGERIES and PROCEDURES***

|  |  |
| --- | --- |
| **Surgery/Procedure** | **Date** |
| Appendectomy |  |
| Bowel Resection |  |
| Colostomy |  |
| Gallbladder Removal |  |
| Hemorrhoid Surgery |  |
| Hernia Repair |  |
| Laproscopy |  |
| Mesh Procedure |  |

|  |  |
| --- | --- |
| **Other Surgeries/Procedures/Significant Injuries** | **Date** |
|  |  |

***SUPPLEMENTS, MEDICATIONS, SUBSTANCES***

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Reason** | **Dosage** | **Frequency** |
| Probiotics |  |  |  |
| Cranberry Supplementation |  |  |  |
| Laxatives |  |  |  |
| Stool Softeners |  |  |  |
| Enemas |  |  |  |
| Other |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please list Medications**(or provide a list) | **Reason** | **Dosage** | **Frequency** |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Substance Use** | **Amount** | **Frequency** |
| Tobacco/Nicotine |  |  |
| Alcohol |  |  |
| Marijuana |  |  |
| Other |  |  |

***PROSTATE/PENILE HEALTH***

**When was your last PSA score?**

**What was your last PSA score?**

**When was your last digital rectal exam?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **√ if No** | **√ If Yes** | **If yes, please describe:** |
| Does your prostate get painful/irritated?  |  |  |  |
| Has your prostate fluid been expressed and tested?  |  |  |  |
| Do you have painful erections?  |  |  |  |
| Are you unsatisfied with your erection? |  |  |  |
| Do you have premature ejaculations? |  |  |  |
| Do you have pain during intercourse? |  |  |  |
| Do you have Urinary Tract Infections? |  |  | **How frequent?****Last infection?** |
| Do you take antibiotics?  |  |  | **Why?****How frequent?** |
| Do you have Yeast Infections?  |  |  | **How frequent?****Last infection?****Treatment?** |

**BLADDER SYMPTOMS**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **√ if No** | **√ if Yes** | **If yes, please describe:** |
| Did you have problems with your bladder during childhood? |  |  |  |
| Do you have leakage associated with sneezing, coughing, laughing, or other activities? |  |  |  |
| Do you have leakage during intercourse? |  |  |  |
| Do you leak at night? |  |  |  |
| Do you have really strong sensations PRIOR to voiding but don’t leak? |  |  |  |
| Does your leakage occur AFTER having a strong urge that feels uncontrollable? |  |  |  |
| Do you have pain when your bladder fills? |  |  |  |
| Does your bladder pain improve when you void? |  |  |  |
| Do you have pain when you void? |  |  |  |
| Do you have difficulty starting your urine stream? |  |  |  |
| Do you have to strain to empty your bladder? |  |  |  |
| Do you have incomplete emptying when you void and feel like you have to go again soon? |  |  |  |
| Do you have dribbling after you get up from the toilet? |  |  |  |
| Do you sit on the toilet? |  |  |  |
| Do you feel your frequency of voiding is abnormal? |  |  | **How many times per day do you void?** |
| Do you get up at night to void?  |  |  | **How often?** |
| Do you have to change your undergarments?  |  |  | **How often?** |
| Do you wear any incontinence pads, depends, etc?  |  |  | **Which ones?****How many per day?** |

***FLUID INTAKE:* Please indicate your fluid intake in cups over a 24 hour period (1 cup=8 oz)**

|  |  |  |
| --- | --- | --- |
|  | **Amount** | **Description** |
| Water |  |  |
| Tea (indicate type) |  |  |
| Coffee |  |  |
| Alcohol |  |  |
| Other Fluids |  |  |

***DIGESTIVE and BOWEL SYMPTOMS***

**What is the frequency of your bowel movements?**

**Do you regularly feel the urge to move your bowels?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **√ if No** | **√ if Yes** | **If yes, please describe:** |
| Do you have constipation? |  |  |  |
| Do you strain to have a bowel movement? |  |  |  |
| Do you have loose stools/diarrhea? |  |  |  |
| Do you have bowel urgency that is difficult to control? |  |  |  |
| Do you lose control of your bowels? |  |  |  |
| Do you have incomplete emptying? |  |  |  |
| Do you have pain WITH a bowel movement? |  |  |  |
| Do you have pain AFTER a bowel movement? |  |  |  |
| Does it take longer than 5 minutes to have a bowel movement? |  |  |  |
| Do you have bloating or increased pressure in the abdomen? |  |  |  |
| Do you experience a physical change in abdominal girth when your bowels are full (distension)? |  |  |  |
| Do you have inadequate fibre intake?  |  |  | If yes: □ Too high □ Too Low |

***SOCIAL HISTORY***

**Does anyone live with you? If yes, please describe:**

**What is your occupation?**

**What is your working status? □ Not working □ Retired □ Full Time □ Part Time**

**Please rate your current job satisfaction from 0-10 (0: not satisfied, 10: extremely satisfied):**

**Please rate your daily stress from 0-10 (0: none, 10: extremely stressed):**

**What are your hobbies and leisure activities?**

**What kind of exercise do you do? Please indicate the frequency.**

**Why is it important to you that you are cared for by Ireland Manual Physiotherapy?**

**How much does this concern bother you from 0-10 (0: not concerned, 10: extremely concerned)?**

**How motivated are you to correct this concern from 0-10 (0: not motivated, 10: extremely motivated)?**

**How hopeful are you from 0-10 that you will improve in the next 3 months? (0: not hopeful, 10: extremely hopeful)?**

**Do you feel there is something dangerously wrong with your body? □ No □ Yes**

**Do you feel that people are not taking you and your concern not seriously enough? □ No □ Yes**

**What goals are you looking to achieve in physiotherapy?**

**Do you have any specific questions you would like answered?**