357 Bay Road
518-632-4944
Fax 518-632-4945

Name _____

Address _____ City/State/Zip _____

Home Ph _____ Cell Ph_____ Email _____

Age _____ Date of Birth _____Preferred method of contact _____

Occupation: _____ Employer Name _____

Emergency Contact Name and Ph Number _____

Referring Physician Name _____

Primary Care Physician Name _____

How did you hear about Innova?_____

Reason for your visit: _____

_____

What makes your condition worse?_____

What makes your condition better?_____

List past surgeries or major medical problems:_____

_____

List medications:_____

What do you hope to gain from physical therapy?_____

History

Number of pregnancies _____ Number of vaginal deliveries _____

Birth weight of largest baby _____ Number of cesarean deliveries _____

Number of episiotomies _____ Date of last pap smear _____

Did you have any trouble healing after delivery Y N

Do you have a history of sexual abuse or trauma Y N

Are you having regular periods/ menstrual cycles Y N

Do you have frequent urinary tract infections Y N

Type of birth control using _____

Pain

Do you have pain with:

Sexual intercourse Y N

Pelvic exam Y N

Tampon use Y N

Back, leg, groin, abdominals Y N

Test results

Urodynamics test Y N Results: _____

Cystoscope Y N Results: _____

Urine test Y N Results: _____

Bowel test Y N Results: _____

Bladder symptoms

Do you lose urine when you:

Cough/ sneeze/ laugh Y N Have a strong urge to urinate Y N

Lift/ exercise/ dance/ jump Y N On the way to the bathroom Y N

Hear running water Y N Other _____

Do you wet the bed Y N

Have burning/ pain with urination Y N

Difficulty starting a stream of urine Y N

Strain to empty your bladder Y N

Feel unable to empty bladder fully Y N

Have a falling out feeling Y N

Have pain with a full bladder Y N

Have an urgency of urination
(a strong urge to urinate) Y N

Urinate more than 7 times/day Y N

How many glasses of fluids do you intake per day? Water ____ Caffeine ____ Alcohol _____
Other _____

Do you wear leakage protection? Y N
What type? _____ How many do you use per day?_____

How old were you when you first started to menstruate? _____ Are/were your cycles regular?_____
Painful?_____

Any history of falls on the pelvis or tailbone? Y N _____

Bowel symptoms

Strain to have a bowel movement	Y	N	Leak / stain feces	Y	N
Include fiber in your diet	Y	N	Have diarrhea often	Y	N
Take laxatives / enema regularly	Y	N	Leak gas by accident	Y	N
Have pain with bowel movement	Y	N			
Have a very strong urge to move your bowels	Y	N			

How often do you move your bowels? _____ per day OR _____per week

Most common stool consistency

liquid ___ soft ___ firm ___ pellets ___ other _____