

# RESTORING YOUR BALANCE, LLC

BRANDI ROBERTSON, MSPT



WOMEN'S HEALTH PHYSICAL THERAPY

BRANDI@RESTORINGYOURBALANCE.COM

WWW.RESTORINGYOURBALANCE.COM

PHONE: 231.855.3330

## PATIENT HISTORY

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

1. Describe the current problem that brought you here? \_\_\_\_\_  
\_\_\_\_\_

2. When did your problem first begin? \_\_\_\_\_ months ago or \_\_\_\_\_ years ago.

3. Was your first episode of the problem related to a specific incident? Y/N  
Please describe and specify date \_\_\_\_\_  
\_\_\_\_\_

4. Since that time is it: staying the same \_\_\_\_\_ getting worse \_\_\_\_\_  
getting better \_\_\_\_\_  
Why or how? \_\_\_\_\_

5. If pain is present, rate pain on a 0-10 scale 10 being the worst. \_\_\_\_\_  
Describe the nature of the pain (i.e. constant burning, intermittent ache) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Describe previous treatment/exercises \_\_\_\_\_  
\_\_\_\_\_

7. Activities/events that cause or aggravate your symptoms.  
Check/circle all that apply:

___ Sitting greater than ___ minutes	___ With cough/sneeze/straining
___ Walking greater than ___ minutes	___ With laughing/yelling
___ Standing greater than ___ minutes	___ With lifting/bending
___ Changing position (i.e.: sit to stand)	___ With cold weather

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1675 LEAHY ST SUITE 210B • MUSKEGON MI 49442 • FAX: 231.726.2412



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## Pg 2 - History - Name \_\_\_\_\_

- \_\_\_ Light activity (light housework)
- \_\_\_ With triggers ie. running water/key in door
- \_\_\_ Vigorous activity/exercise (run/weight lift/jump)
- \_\_\_ With nervousness/anxiety
- \_\_\_ Sexual activity
- \_\_\_ No activity affects the problem
- \_\_\_ Other, please list \_\_\_\_\_

8. What relieves your symptoms? \_\_\_\_\_

9. How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify \_\_\_\_\_

Diet /Fluid intake, specify \_\_\_\_\_

Physical activity, specify \_\_\_\_\_

Work, specify \_\_\_\_\_

Other \_\_\_\_\_

10. Rate the severity of this problem from 0-10 with 0 being no problem and 10 being the worst \_\_\_\_\_

11. What are your treatment goals/concerns? \_\_\_\_\_

### Since the onset of your current symptoms have you had:

- Y/N Fever/Chills
- Y/N Malaise (Unexplained tiredness)
- Y/N Unexplained weight change
- Y/N Unexplained muscle weakness
- Y/N Dizziness or fainting

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## Pg 3 - History - Name \_\_\_\_\_

Y/N Night pain/sweats

Y/N Change in bowel or bladder functions

Y/N Numbness / Tingling

Y/N Other /describe \_\_\_\_\_

**Health History:** Date of Last Physical Exam \_\_\_\_\_

Tests performed: \_\_\_\_\_

**General Health:** Excellent Good Average Fair Poor

Occupation \_\_\_\_\_

Hours/week \_\_\_\_\_ On disability or leave? \_\_\_\_\_ Activity Restrictions? \_\_\_\_\_

**Mental Health:** Current level of stress High \_\_\_\_\_ Med \_\_\_\_\_ Low \_\_\_\_\_

Current psychotherapy? Y/N

**Activity/Exercise:** None 1-2 days/week 3-4 days/week 5+ days/week

Describe \_\_\_\_\_

**Have you ever had any of the following conditions or diagnoses?**

**Circle all that apply/describe**

Alcoholism/Drug problem

Allergies (list)

Anemia

Ankle swelling

Anorexia/bulimia



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## Pg 4 - History - Name \_\_\_\_\_

Arthritic conditions  
Asthma  
Bone Fracture  
Cancer  
Childhood bladder problems  
Chronic Fatigue Syndrome  
Depression  
Diabetes  
Emphysema/chronic bronchitis  
Epilepsy/seizures  
Fibromyalgia  
Head Injury  
Head Injury  
Headaches  
Hearing loss/problems  
Heart problems  
Hepatitis  
High Blood Pressure  
HIV/AIDS  
Hypothyroid/ Hyperthyroid  
Irritable Bowel Syndrome  
Joint Replacement  
Kidney disease  
Latex sensitivity  
Low back pain  
Multiple sclerosis  
Osteoporosis  
Pelvic pain  
Physical or Sexual abuse

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## Pg 5 - History - Name \_\_\_\_\_

Reynaud's (cold hands and feet)  
Rheumatoid Arthritis  
Sacroiliac/Tailbone pain  
Sexually transmitted disease  
Smoking history  
Sports Injuries  
Stress fracture  
Stroke  
TMJ/ neck pain  
Vision/eye problems

Other/Describe \_\_\_\_\_

### **Surgical /Procedure History**

Y/N Surgery for your back/spine  
Y/N Surgery for your bladder/prostate  
Y/N Surgery for your brain  
Y/N Surgery for your bones/joints  
Y/N Surgery for your female organs  
Y/N Surgery for your abdominal organs  
Other/describe \_\_\_\_\_

### **Ob/Gyn History (females only)**

Y/N	Childbirth vaginal deliveries # _____	Y/N	Vaginal dryness
Y/N	Episiotomy # _____	Y/N	Painful periods
Y/N	C-Section # _____	Y/N	Menopause - when? ____
Y/N	Difficult childbirth # _____	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain
Y/N	Other /describe _____		

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## Pg 6 - History - Name \_\_\_\_\_

**Medications - pills, injection, patch**

**Start date, Reason for taking**

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**Over the counter – vitamins, etc.**

**Start date, Reason for taking**

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## PELVIC SYMPTOM QUESTIONNAIRE

### Bladder / Bowel Habits / Problems

- Y/N Trouble initiating urine stream
- Y/N Blood in urine
- Y/N Urinary intermittent /slow stream
- Y/N Painful urination
- Y/N Trouble emptying bladder
- Y/N Trouble feeling bladder urge/fullness
- Y/N Difficulty stopping the urine stream
- Y/N Current laxative use
- Y/N Trouble emptying bladder completely
- Y/N Trouble feeling bowel/urge/fullness
- Y/N Straining or pushing to empty bladder
- Y/N Constipation/straining
- Y/N Dribbling after urination
- Y/N Trouble holding back gas/feces
- Y/N Constant urine leakage
- Y/N Recurrent bladder infections
- Y/N Other/describe \_\_\_\_\_

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## Pg 7 - History - Name \_\_\_\_\_

1. Frequency of urination: awake hour's \_\_\_\_\_ times per day, sleep hours \_\_\_\_\_ times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? \_\_\_\_\_ minutes, \_\_\_\_\_ hours, \_\_\_\_\_ not at all
3. The usual amount of urine passed is: \_\_\_small \_\_\_ medium\_\_\_ large.
4. Frequency of bowel movements \_\_\_\_\_ times per day, \_\_\_\_\_ times per week, or \_\_\_\_\_.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? \_\_\_\_\_ minutes, \_\_\_\_\_ hours, \_\_\_\_\_ not at all.
6. If constipation is present describe management techniques \_\_\_\_\_  
\_\_\_\_\_
7. Average fluid intake (one glass is 8 oz or one cup) \_\_\_\_\_ glasses per day. Of this total how many glasses are caffeinated? \_\_\_\_\_ glasses per day.
8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:  
\_\_\_ None present  
\_\_\_ Times per month (specify if related to activity or your period)  
\_\_\_ With standing for \_\_\_\_\_ minutes or \_\_\_\_\_ hours.  
\_\_\_ With exertion or straining  
\_\_\_ Other \_\_\_\_\_



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## Pg 8 - History - Name \_\_\_\_\_

Skip questions if no leakage/incontinence:

9a. Bladder leakage - number of episodes

- No leakage
- Times per day
- Times per week
- Times per month
- Only with physical exertion/cough

9b. Bowel leakage - number of episodes

- No leakage
- Times per day
- Times per week
- Times per month
- Only with exertion/strong urge

10a. On average, how much urine do you leak?

- No leakage
- Just a few drops
- Wets underwear
- Wets outerwear
- Wets the floor

10b. How much stool do you lose?

- No leakage
- Stool staining
- Small amount in underwear
- Complete emptying



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## Pg 9 - History - Name \_\_\_\_\_

11. What form of protection do you wear? (Please complete only one)

\_\_\_ None

\_\_\_ Minimal protection (tissue paper/paper towel/pantishields)

\_\_\_ Moderate protection (absorbent product, maxipad)

\_\_\_ Maximum protection (specialty product/diaper)

\_\_\_ Other \_\_\_\_\_

On average, how many pad/protection changes are required in 24 hours?

\_\_\_ # of pads

