PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name:_____ **Age**_____ **Why are you here?**_____

Check all the Conditions that apply to you:

HEART/CIRCULATION	√	**MEDICAL PROBLEMS**	√	***URO/GYNECOLOGICAL HISTORY***	
Heart Disease/Surgery		___Diabetes ____Thyroid		Date of Last Pap Smear:	
High Blood Pressure		Cancer		Do you have pain with sexual intercourse	Yes No NA
Pain/tightness in chest		IBS		Do you have any current infections or yeast	Yes No
Numbness in hands/feet		Anxiety or panic attacks		Do you have a "falling out" feeling	Yes No
		Depression		Do you have urinary leakage	Yes No
BONES & JOINTS		Excessive stress		Do you have urinary frequency and/or urgency	Yes No
Chronic Fatigue Syndrome		**LUNG/BREATHING**			
Arthritis		Shortness of Breath		***ABDOMINAL DISCOMFORT or PAIN***	Yes No
Fibromyalgia		Smoke cigarettes now		If yes, complete this section	
Tailbone pain		**AREAS OF PAIN**		Pain is ___constant __burning __crampy __wakes me up	
Joint Replacements		Back		Pain get worse with ___eating __bowel movement ___emotional stress ___constipation ___menstrual period ___other:	
FAMILY HISTORY		Rectal pressure			
Skin cancer		Rectal ___pain __burning		Pain/discomfort is relieved with __eating ___bowel movement ___exercise ___other:	
Digestive problems		Vulvar or vaginal area			
Heart disease		**FOOD INTOLERANCE**		***BOWEL HISTORY***	
High Blood Pressure		__Milk __red meat		Can you tell if there is solid, liquid or gas in the rectum	Yes No
SURGICAL HISTORY		__Spicy foods __peanuts		Do you feel the urge to move your bowels	Yes No
Rectocele Repair		**CHILDBEARING**		Is the urge very strong or difficult to control	Yes No
Surgery for hemorrhoids		Pregnant now		Is the urge weak or absent	Yes No
Abdominal Hysterectomy		Trying to get pregnant		Do you leak gas	Yes No
Vaginal Hysterectomy		# of vaginal deliveries		Do you have constipation	Yes No
Bladder surgery		# of C-Sections		Do you use ___enemas or _____laxatives	Yes No
Pudendal Nerve Surgery		**DO YOU HAVE**		Do you strain to have a bowel movement	Yes No
Back Surgery		Abdominal bloating		Do you leak feces ___Yes ___No	
Bowel surgery		Nausea or vomiting		If yes, is the stool that leaks out ___liquid ___soft __solid	
Radiation to pelvis/bowel		Trouble swallowing		Is the leakage of stool associated with activity?	Yes No
ALLERGIES		Burping or belching with acid into the mouth		__lifting __coughing __running __what I eat __ Leak after bowel movement ←	If yes, what causes leakage
Latex (gloves, condoms)		Excessive belching		Do you often ignore the urge to have a bowel movement	Yes No
FALLS, TRIPS, SLIPS		Indigestion		Do you pass mucus from the rectum	Yes No
Dizziness		Feeling full with little food		Do you feel the rectum is empty when you finish a BM	Yes No
#Falls the last 6 mos.		Excessive passing of gas from the rectum		Is your stool __pencil thin ___pellets ___large __Liquid __Soft (like peanut butter) __Firm (like banana) ___Hard	
# trips/slips/near falls		Weight loss/loss of appetite		How often do you have a bowel movement: __More than 4 times per day __2-3 times per day __Daily __Every other day __Every 4-7 days	

LIST ALL THE MEDICATIONS YOU ARE TAKING, INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS:

Name of Medication	For what?	Name of Medication	For What?

Complete this Section ONLY if you are having fecal leakage ***0****= Never (No episodes in the last 4 wks)* ***1****=Rare (1 episode in the last 4 wks)* ***2****=Sometimes (more than once in last 4 weeks but less than once/week* ***3****=Weekly (one or more episodes per week but less than daily* ***4****= 1 or more times everyday/everytime*	Circle what applies to you
Incontinence (leakage) of Solid Stool	*0 1 2 3 4*
Incontinence (leakage) of Liquid Stool	*0 1 2 3 4*
Incontinence (leakage) of Gas	*0 1 2 3 4*
Need to Wear Pads (How many pads per day _____)	*0 1 2 3 4*
Take medications for _____Constipation or _____diarrhea	*0 1 2 3 4*
Cannot postpone urge to have bowel movement for 15 minutes after feeling the need to go	*0 1 2 3 4*
ALL PATIENTS SHOULD COMPLETE THE SECTION BELOW	
I have a bowel movement ***more than*** 3 times per day at least 25% of the time	No Yes
I have a bowel movement ***less than*** 3 times per week at least 25% of the time	No Yes
I have to strain to have bowel movements (holding your breath and bearing down) *0=No problem 1= very small problem 2=Small problem 3= medium problem 4=Big Problem*	*0 1 2 3 4*
I feel I do not empty my bowels completely *0=No problem 1= very small problem 2=Small problem 3= medium problem 4=Big Problem*	*0 1 2 3 4*
My abdomen (lower belly) feels bloated or distended *0=No problem 1= very small problem 2=Small problem 3= medium problem 4=Big Problem*	*0 1 2 3 4*
I use my fingers/hand to empty my bowels at least once out of every 4 bowel movements *0=No problem 1= very small problem 2=Small problem 3= medium problem 4=Big Problem*	*0 1 2 3 4*
Stool Consistency (check all that apply) *___ Hard pellets ___ Like banana ___Like peanut butter ___ Watery __thin, pencil like __large*	
If you have IBS, what is the length of one IBS episode *0= I do not have IBS* ***1****= 1 day or less* ***2*** *= more than 2 days, less than 1 week* *3= More than 1 week, less than 2 weeks* ***4****= 2-4 weeks* ***5****= Month* ***V****= Varies depending on diet/medication* ***C****= continuous*	*0 1 2* *3 4 5* *V C*
How satisfied are you with your bowel habits *0= very satisfied 1= good deal satisfied 2=moderately satisfied* *3=hardly satisfied 4= not at all satisfied*	*0 1 2 3 4*
How do your bowel symptoms impact your Daily Life *0=No problem 1= very small problem 2=Small problem 3= medium problem 4=Big Problem*	
Affects choice of clothing	*0 1 2 3 4*
Affects quantity of food eaten	*0 1 2 3 4*
Affects type of food eaten	*0 1 2 3 4*
Interferes with social activity (movies, dancing, church, visiting, travel)	*0 1 2 3 4*
Affects sex life/relationship with partner	*0 1 2 3 4*
I feel depressed, anxious, embarrassed, frustrated, angry	*0 1 2 3 4*
I worry that I smell	*0 1 2 3 4*
Other	

SOCIAL, OCCUPATIONAL AND RECREATIONAL ACTIVITIES

Marital Status: __Single __Married ___Separated __Divorced ___Dating

Do you feel safe at home? ___Yes ____ No Comment:_____

Occupation:_____ Physically this means I ___sit ___stand __walk most of the day

Educational Level _____ **Hobbies**: _____ _____

EXERCISE HISTORY:
___No exercise ___Walk _____ ____Go to gym _____

CHECK THE WORDS THAT APPLY TO HOW YOU FEEL THESE DAYS &/OR CHOOSE YOUR OWN WORDS:

DESCRIPTOR	√		√		√		√		√		√		√
Happy →		Calm →		Unmotivated		Stressed		Lonely		Content		Depressed	
Overwhelmed →		Sad →		Tired		Afraid		Energetic		Optimistic		"Postpartum blues"	
Flabby →		Strong →		Un-rested		Lethargic		Weak		Overworked		Not bonding with baby(ies)	
Anxious →		Unsafe →		Abused		Neglected							

HOW DO YOU LEARN?: ___Listening (lecture, discussion) ___Seeing (read, video, DVD) __Doing (practicing skill)

Is English your primary language? ___Yes ____No. If no, would you need a translator when you are in therapy? _____

NUTRITION: How much do you weigh? _____pounds

Would you like to ___lose or ____gain weight?	Yes No	
Have you gained/ lost more than 10 pounds in the last year?	Yes No	
Are you on any special diet?	Yes No	__Low Carb ___Atkins ___South Beach __Weight Watchers __Diabetic __Other_____
Would you say your diet is "unhealthy"?	Yes No	__too many fast foods __Not enough vegetables __High Fat __High Carb __Other_____

FLUID INTAKE: What do you drink every day?
____8 ounce glasses of water ___cans of diet soda ___cans of regular soda ___8 ounce cups of regular coffee
____8 ounce cups of decaffeinated coffee ____8-ounce cups/glasses of tea ____16-ounce cans of beer
____glasses of wine ___glasses of liquor ___ 8-ounce glasses of milk ____8-ounce glasses of juice_____
____Other_____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ____None or:

TREATMENTS	HAS IT HELPED?	TREATMENTS	HAS IT HELPED?
Medication(s)	Yes No A little	Surgery	Yes No A little
Physical Therapy	Yes No A little	Other	Yes No A little

What started this problem? _____