



**Women's Center for Wellness and Rehabilitation**

Evaluation for Trunk, pelvis and leg pain – Pregnancy and Postpartum

DEMOGRAPHIC AND INSURANCE INFORMATION (PHYSICAL THERAPY DEPARTMENT)

**PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE**

Name: \_\_\_\_\_ Why are you here? \_\_\_\_\_

Check all the Conditions that apply to you:

HEART/CIRCULATION	v	MEDICAL PROBLEMS	v	FOR WOMEN ONLY
Heart Disease		Diabetes		<b><u>CHILDBEARING HISTORY</u></b>
<input checked="" type="checkbox"/> High Blood Pressure		Fainting Spells		Are you Pregnant? Yes No
Pacemaker		Cancer		If yes, what is your due date: _____
Heart Surgery		<input checked="" type="checkbox"/> Dizziness		
Pain/tightness in chest		Thyroid Problems		If yes, are you planning to breastfeed? Yes No Don't Know
<input checked="" type="checkbox"/> Stroke		<input checked="" type="checkbox"/> Falls the last 6 mos.		# of Pregnancies – If this is your first pregnancy, skip the next section 0 1 2 3 4 5 +
<b>BONES &amp; JOINTS</b>		<input checked="" type="checkbox"/> # trips/slips/near falls		<b>COMPLETE THE SECTION BELOW ONLY IF YOU HAVE HAD MORE THAN ONE PREGNANCY.</b>
Osteoporosis		<input checked="" type="checkbox"/> Depression		
Scoliosis		<b>LUNG/BREATHING</b>		
Fibromyalgia		Difficulty breathing		# of Children (circle one number) 0 1 2 3 4 5 +
Plantar fasciitis		Shortness of Breath		
Dropped arches/flat feet		Smoke cigarettes now		# of Miscarriages (circle one number) 0 1 2 3 4 5 +
<input checked="" type="checkbox"/> Numbness in feet/legs		History of smoking		# of Vaginal deliveries (circle) 0 1 2 3 4 5 +
Tailbone fracture		<b>SURGICAL HISTORY</b>		
Joint Replacements		Back or neck		# of C-Sections (circle one number) 0 1 2 3 4 5 +
Swelling in Ankles/feet		Tubal Ligation		
<b>AREAS OF PAIN</b>		Laproscopy		Birth weight of largest baby
Back ("sciatica like pain")		Abdominal Hysterectomy		
Neck		Vaginal Hysterectomy		# of episiotomies (circle one number) 0 1 2 3 4 5 +
Ribs		Gall Bladder		
Shoulders		Bladder surgery		# of forceps deliveries 0 1 2 3 4 5 +
Abdomen/belly		<b>FAMILY HISTORY</b>		
Tailbone		Heart Disease		<b>IF YOU ARE NOT PREGNANT, PLEASE COMPLETE THE SECTION BELOW</b>
Wrist ("carpal tunnel")		High Blood Pressure		
Swelling in the hands		Diabetes		Are you trying to get pregnant Yes No
Feet		Cancer		Do you have symptoms of leaking urine Yes No
Knees		Stroke		Do you have constipation Yes No
Hips		Osteoporosis		Do have pain with sexual intercourse Yes No
Other				

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

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

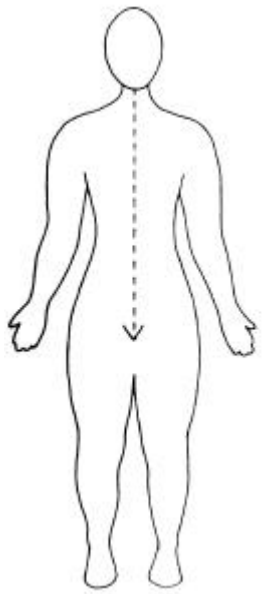


# Women's Center for Wellness and Rehabilitation

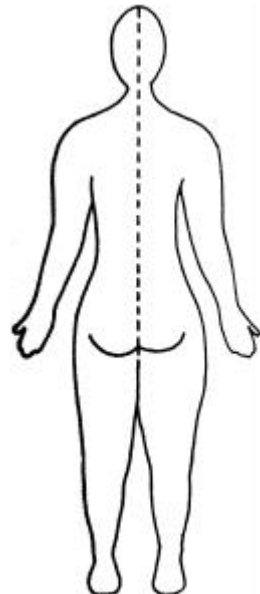
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## TELL US ABOUT YOUR PAIN

Please mark with an "X" where your pain begins. Shade any other areas of pain



FRONT



BACK

### CHECK ALL THE WORDS THAT DESCRIBE YOUR PAIN:

Numb  Stabbing  Burning  Irritating  Aching  Throbbing  Tender  Unbearable  Shooting  
 Sharp  Constant  Other \_\_\_\_\_

### WHAT MAKES YOUR PAIN WORSE?

Sitting  standing  Walking  Getting out of bed  exercise  sexual intercourse  menses  
 Getting up from sitting position  Working at home all day  Being at work all day  Exercise  
 Other \_\_\_\_\_

### WHAT MAKES YOUR PAIN BETTER?

Heating pad  Ice pack  Resting in bed  Resting in Chair  walking  Medication  Exercise  
 Other \_\_\_\_\_

### CHECK ALL THE STATEMENTS THAT ARE TRUE:

I have numbness or tingling in my legs  I have numbness or tingling in my arms or hands  
 There is a change in the way my bladder or bowels work since this problem started  
 I feel dizzy  I have blurred vision.

### WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? None or:

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