INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET
Pelvic Girdle (Page 1)

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

SUBJECTIVE

Age: _____ **When did your symptoms start?** _____
When was your last Gynecological exam: _____
Describe the current problem that brought you here: _____
_____
_____
Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same
Have you had any testing? ☐ X-rays ☐ Urinalysis ☐ Post Void Residual ☐ Other
Results: _____
Have you ever had these symptoms before? ☐ Yes ☐ No **Description:** _____
Have you ever had treatment before for these symptoms? ☐ Yes ☐ No **If Yes, please describe:**
☐ **Medication:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____
☐ **Physical Therapy:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____
☐ **Other:** _____ **Beneficial?** ☐ Yes ☐ No **Explain:** _____
Did you have surgery? ☐ Yes ☐ No **Date of Surgery:** _____
If yes, what procedure did you have done? _____
Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?
☐ Yes ☐ No **Explain:** _____

THERAPIST COMMENTS:

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

Occupation: _____ **Presently Working:** ☐ Yes ☐ No
If Yes, ☐ Full Duty ☐ Limited Duty: **Restrictions:** _____ **# Days Off Work:** _____
Job Duties: ☐ Sitting ☐ Computer Work ☐ Bending ☐ Heavy Lifting ☐ Traveling ☐ Standing
☐ Reaching ☐ Crawling ☐ Twisting ☐ Walking ☐ Pushing/Pulling ☐ Gripping/Pinching
☐ Other: _____
Are you now, or have you ever been disabled (service or work)? ☐ Yes ☐ No **If Yes, when?** _____
If Yes, please explain: _____
What is your current living arrangement? ☐ Alone ☐ Spouse ☐ Partner ☐ Family ☐ Other: _____
Does your home have stairs? ☐ Yes ☐ No **If Yes, # of stairs:** _____
If Yes, do your stairs have handrail? ☐ Yes ☐ No **If Yes, which side going up?** ☐ Right ☐ Left ☐ Both
Do you currently use any Tobacco products? ☐ Yes ☐ No **If yes, what type?** _____ **Frequency:** _____

THERAPIST COMMENTS:

FUNCTIONAL ABILITIES AND RESTRICTIONS

What were you doing prior to this injury that you are unable to do currently? Please list any additional activities that you are having difficulty completing. _____
☐ Squatting ☐ Sitting ☐ Driving ☐ Reaching ☐ Work Tasks ☐ Gripping/Pinching
☐ Standing ☐ Walking ☐ Lifting ☐ Dressing/Grooming ☐ Stairs ☐ Position Changes
☐ Kneeling ☐ Holding/Carrying Objects ☐ Other: _____
Hobbies/ Interests/ Exercise: _____
What activities make your <u>symptoms</u> WORSE? _____
What activities make your <u>symptoms</u> BETTER? _____
How severe is this problem? ***(0 = Not Severe, 10 = Extremely Severe)***

How much is this problem controlling your life? ***(0= Not Controlling, 10 = Extremely Controlling)***

What were you doing previously that you are currently unable to do or are avoiding? _____
_____
Do you use an assistive device? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

THERAPIST COMMENTS:

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET
Pelvic Girdle (Page 2)

Patient Name: _____ Date of Birth: _____ Date of Eval: _____

PREVIOUS MEDICAL HISTORY/ MEDICAL PRECAUTIONS AND CONTRAINDICATIONS

SURGICAL HISTORY

□ Surgery for Back/Spine □ Surgery for Abdominal Organs □ Surgery for Bowel □ Surgery for Female Organs
□ Surgery for Hips □ Surgery for Bladder □ Surgery for Prostate □ Other:_____

OB/ GYN HISTORY

□ Menopause □ Painful Periods □ Currently Pregnant: # Weeks_____ □ Episiotomy: # _____
□ Prolapse □ Painful Penetration □ Pregnancies: # _____ □ C-Sections: # _____
□ Hormone Therapy □ Vaginal Dryness □ Vaginal Deliveries: #_____

Is there any other information regarding your medical history that we should know about? _____

THERAPIST COMMENTS:
□ **See Attached List**

BOWEL AND BLADDER HABITS

How much do you drink daily? #8 oz. Water ____#8 oz. Caffeine____#8 oz. Alcohol____#8 oz. Other_____

If you have leakage, do you leak: □ **Urine** □ **Feces** □ **Gas** If Yes, # of times: Daily_____ Weekly_____ Monthly _____ If Yes, □ Minimal □ Moderate □ Severe

Do you take your time to go to the toilet and empty your bladder? □ **Yes** □ **No**

Do you have trouble making it to the toilet on time when you have the urge? □ **Yes** □ **No**

Have you had a bladder infection in the last year? □ **Yes** □ **No** **If Yes, # times _____**

Have you had the feeling you have a bladder infection but did not? □ **Yes** □ **No**

Can you stop the flow of urine when on the toilet? □ **Yes** □ **No**

Do you strain to pass urine? □ **Yes** □ **No**

Do you have the sensation that you need to go to the toilet? □ **Yes** □ **No**

Do you have the feeling your bladder is still full after urinating? □ **Yes** □ **No**

Do you have a slow or hesitant urinary stream? □ **Yes** □ **No**

Do you have difficulty initiating urine stream? □ **Yes** □ **No**

Do you empty your bladder before you feel the urge to pass urine? (just in case) □ **Yes** □ **No**

Do you ignore the urge to defecate? □ **Yes** □ **No**

Do you have a history of constipation? □ **Yes** □ **No**

How long can you delay bowel movement?
□ Not at all □ 1-2 minutes □ 3-10 minutes □ 11-30 minutes □ 31-60 minutes □ _____ hours

How long can you delay the need to urinate?
□ Not at all □ 1-2 minutes □ 3-10 minutes □ 11-30 minutes □ 31-60 minutes □ _____ hours

Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, etc.)
□ Yes □ No Explain:_____

Do your symptoms worsen with certain foods/drink? □ **Yes** □ **No** **Explain: _____**

Do you leak when you: □ Cough □ Sneeze □ Run □ Jump □ Walk to toilet □ During sexual activity
□ Other _____

Do you wear incontinence protection? □ **Yes** □ **No**
If Yes, # used per day: □ Pantishield_____ □ Minipads_____ □ Maxipad_____
□ Other_____

THERAPIST COMMENTS:

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking (including over-the-counter, prescriptions, herbals, and vitamins/minerals):

_____

_____

THERAPIST COMMENTS:
□ **See Attached List**

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? _____

THERAPIST COMMENTS:

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ Date: _____