

INTEGRATED PHYSICAL THERAPY OF LITTLETON, P.C.

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PHYSICAL THERAPY SCREENING QUESTIONNAIRE FOR PELVIC PAIN

Please take a few moments to fill out the following patient questionnaire so that we may better serve you. Answering the following questions will assist us in your evaluation and treatment. Thanks for your help!

Name: _____ Date: _____

1. Right Handed () Left Handed () 2. Do you smoke? Yes / No

3. Are you currently working? Yes / No Occupation: _____

4. Date of Accident/ Onset of Problems: _____

5. Dates of work missed due to injury: _____

6. Has your doctor given you any activity limitations? Yes / No

If yes, what are they? _____

7. Please circle any FAMILY history of:

Heart Disease Gout Osteoprosis Rheumatoid Arthristis
Cancer Hemophilia Diabetes Sickle Cell Anemia
Osteoarthritis Psoriasis

8. Please circle any PERSONAL history of:

Diabetes Anemia Gout Hypoglycemia Seizures Blood Clots
Psoriasis Pneumonia Arthritis High Blood Pressure Tumors
Current Pregnancy Metal Implants Pacemaker

Other: _____

9. Please circle any of the following problems which you now have or which you have had within the past year:

Weight Gain Weight Loss Appetite Change Fatigue Weakness
Night Pain Chest Pain Numbness Palpitations Night Sweats
Urinary Tract Infection Dizziness Hospitalization Mental Lethargy
Restlessness/ Disturbed Sleep Shortness of Breath Heart Problems

Other: _____

10. Please circle any of the following specific tests that have been performed for your PRESENT condition:

X-Rays Halter Monitor Stress Test EMG Cat Scan MRI
Electrocardiogram Lab Work (ie. Blood tests) Nerve Conduction Velocity

Other: _____

11. Have you had any similar past injuries or ailments? Yes / No

If yes, please explain: _____

PELVIC PAIN QUESTIONNAIRE

Name: _____ Date: _____

Please rate your pain from NONE (0) to SEVERE (3) on each of the following:

| | NONE 0 | MILD 1 | MODERATE 2 | SEVERE 3 |
|---------------------------|-----------|-----------|---------------|-------------|
| 1. Throbbing | | | | |
| 2. Shooting | | | | |
| 3. Stabbing | | | | |
| 4. Sharp | | | | |
| 5. Cramping | | | | |
| 6. Gnawing | | | | |
| 7. Hot/ Burning | | | | |
| 8. Aching | | | | |
| 9. Tender | | | | |
| 10. Splitting | | | | |
| 11. Tiring/ Exhausting | | | | |

Please list the areas where you experience pain:
