Men's Health Patient Health History and Information

Name: _____ Date of Birth: _____ Date: _____

Age: _____Height: _____ Weight: _____ Hand Dominance: Right Left

Emergency Contacts

1) Name: _____Relation:_____Contact #:_____

2) Name: _____Relation:_____Contact #:_____

Describe the problem that brought you to Atlas Therapy: _____

_____

SYMPTOMS

When did your symptoms begin? _____ Are they: Improving Getting Worse Staying the same

Have you ever had any of these symptoms before (circle)? YES (Describe): _____ NO

Have you ever had any treatment for these symptoms (circle)? YES (see below) NO

Medication	Beneficial?	YES	NO	Explain: _____
Injection	Beneficial?	YES	NO	Explain: _____
Physical Therapy	Beneficial?	YES	NO	Explain: _____
Massage/Chiropractic	Beneficial?	YES	NO	Explain: _____

If you had any testing, circle all that apply and provide the results if you're able.

X-Rays: Results: _____ **MRI**: Results: _____

CT Scan: Results: _____ **Other**: Results: _____

EMG/Nerve Conduction Test: Results: _____

Did you have surgery (circle)? NO YES (Date): _____ What? _____

PAIN INFORMATION

Where is the location of your pain? _____

Please indicate your pain level on a scale of 0-10, with 0 being no pain, 5 moderate pain and 10 being extreme pain.

	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
At worst:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Current:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At Best:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you have pain with sexual intercourse? YES NO

Do you have back, leg, groin, abdominal pain? YES NO

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Incontinence Questions

Are you able to void at the toilet? YES NO
Is the urge to void present? YES NO
Is there pain or burning when you void? YES NO
Is it difficult to start your urine flow? YES NO
Do you have a weak stream? YES NO
Do you experience dribbling after voiding? YES NO
How many pads/diapers each day? _____
Are your pads thick or thin? _____
Are they damp, wet, or soaked when changed? _____
How many times do you get up at night to void? _____
How many pads do you wear through the night? _____
Are they damp, wet, or soaked when changed? _____

Do you lose urine when you:

Have a strong urge?	YES	NO
See, hear or feel water?	YES	NO
Move from sit to stand?	YES	NO
Lift heavy objects?	YES	NO
Sneeze, cough or laugh?	YES	NO
Walk, run or exercise?	YES	NO
Sleep?	YES	NO
Other?	YES	NO

TEST RESULTS

Urodynamics test:	YES	NO	Results: _____
Cystoscope:	YES	NO	Results: _____
Urine Test:	YES	NO	Results: _____
Bowel Test:	YES	NO	Results: _____
Other:	YES	NO	Results: _____

GENERAL HEALTH HISTORY

Have you had any falls or near falls in the past year? YES NO
Do you exercise? YES NO If yes, how many times per week? _____
Do you smoke? YES NO Have you ever smoked? YES NO
Do you drink caffeinated beverages? YES NO

ATLAS THERAPY

Men's Health Patient Health History and Information

Do you or have you had cancer? YES NO If yes, when? _____ Type? _____ Location? _____
Rate your overall health. GOOD FAIR POOR OTHER_____

Please list any surgeries you've had including the date. _____

_____

_____

Please check ALL that apply to your general health.

- ☐ Pacemaker
- ☐ Seizures/Epilepsy
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Allergies: Type_____
- ☐ Asthma/Breathing Difficulties
- ☐ Cancer
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Anemia
- ☐ Stroke/TIA
- ☐ Hypoglycemia
- ☐ Polio
- ☐ Kidney Problems
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Palpitations
- ☐ Chest Pain/ Angina
- ☐ Hernia
- ☐ Liver/Gallbladder Problem
- ☐ Skin Abnormalities
- ☐ Physical Abnormalities
- ☐ Intolerance to Cold
- ☐ Intolerance to Heat
- ☐ Depression
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Metal Implants
- ☐ Sexual Dysfunction
- ☐ Night Pain
- ☐ Unexplained Weight Change
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Numbness/Tingling in Hip/Buttocks Area
- ☐ Ringing of the Ears
- ☐ Pain with Cough/Sneeze
- ☐ Urine Leakage
- ☐ Recent Headaches
- ☐ Recent Vision Changes
- ☐ Recent Nausea/Vomiting
- ☐ Recent Dizziness/Fainting
- ☐ Recent Unexplained Fatigue
- ☐ Recent Changes in Bowel/Bladder Habits
- ☐ Recent Fractures
- ☐ Recent Fever
- ☐ Other_____

What is your daily fluid intake:
Water: _____oz. Caffeine: _____oz. Alcohol: _____oz. Other: _____oz.

Urination Frequency:
How many times during the day? _____ How many times during the evening? _____
How long between voids? Less than 1 Hour 1-2 Hours 3-4 Hours More than 4 Hours

Bowel Frequency:
How many times during the day? _____ How many times during the evening? _____
What is your common stool consistency? Liquid Soft Formed Pellets

ATLAS THERAPY

Men's Health Patient Health History and Information

The past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things:

Not at all Several Days More than one half the days Nearly every day

Feeling down, depressed, or hopeless:

Not at all Several Days More than one half the days Nearly every day

WORK HISTORY

Occupation: _____ Are you presently working? YES NO

If yes, please circle if you're working: FULL DUTY Limited Duty with Restrictions (what): _____

If no, please indicate the number of workdays lost due to condition: _____

Current Job Duties:

- ☐ Sitting
- ☐ Computer Work
- ☐ Bending
- ☐ Heavy Lifting: Mass Amount _____
- ☐ Traveling
- ☐ Standing
- ☐ Other: _____
- ☐ Reaching
- ☐ Crawling
- ☐ Twisting
- ☐ Walking
- ☐ Pushing/Pulling
- ☐ Gripping/Pinching

PATIENT THERAPY GOALS

What are your goals for participating in therapy?

_____

_____

Patient Signature: _____ Date: _____