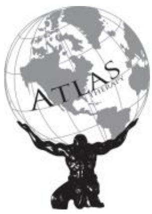


Women's Health
Patient Health History and Information

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.

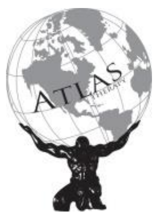
	0	1	2	3	4	5	6	7	8	9	10
At worst:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Current:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At Best:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HISTORY

Number of pregnancies: _____________ Number of vaginal deliveries: ___________

Birth weight of largest baby: __________ Number of cesarean deliveries: __________

Number of episiotomies: _____________ Date of last pap smear: ________________



Women's Health
Patient Health History and Information

Did you have trouble healing after delivery? YES NO
Do you have a history of sexual abuse or trauma? YES NO
Are you having regular periods/ menstrual cycles? YES NO
Do you have frequent urinary tract infections? YES NO

PAIN

Do you have pain with:

- Sexual Intercourse YES NO
- Pelvic Exam YES NO
- Tampon Use YES NO

Do you have back, leg, groin, abdominal pain? 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: ______________________

Obstetrical/Gynecological History

Are you sexually active? YES NO
Do you have vaginal dryness? YES NO
Do you, or have ever had, a sexually transmitted disease? YES NO Type/s: _____________________________
Are you currently pregnant or attempting pregnancy? YES NO

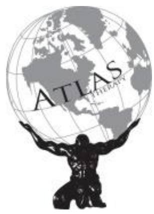
GENERAL HEALTH HISTORY

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
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. ____

____

____



Women's Health
Patient Health History and Information

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.

<u>Urination Frequency:</u>

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

<u>Bowel Frequency:</u>

How many times during the day? ________   How many times during the evening? ________

What is your common stool consistency?   Liquid   Soft   Formed   Pellets

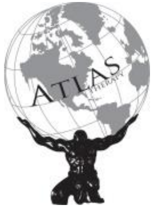
The past two weeks, how often have you been bothered by any of the following problems?

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



Women's Health
Patient Health History and Information

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 work days 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: ____________________