Apex Physical Therapy & Wellness Center

"Caring Hands for Curing Pain!"

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VISCERAL HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient Name: ______________________________ Date:____________

Patient History and Symptoms

Please fill in the following questionnaire to the best of your ability.
What is the primary complaint you are being seen for?____

____

When did this problem begin? (Date, approximate if known)____

Do you currently have the following symptoms?

Y/N Pelvic pain Y/N Blood in urine
Y/N Low back pain Y/N Kidney Infections
Y/N Bladder Infections Y/N Latex sensitivity/allergy
Y/N Internal Foreign Objects (Staples, lap band, IUD, pacemaker, mesh, etc)

If you answered "Yes" to any of the previous questions, please explain:

____
____
____

Health History

Please CIRCLE any of the following health conditions that you now have or had in the past.
None

None	Unexplained weight loss	Tuberculosis	Cancer	Chemical dependency
Kidney disease	Diabetes	Smoker	Anemia	High blood pressure
Seizures	Stroke	Heart problems	Currently pregnant	Osteoporosis/ Osteopenia
Rheumatoid arthritis	History of fractures	Osteoarthritis	Asthma	Menopausal
Thyroid disease	Incontinence	Emphysema	Multiple sclerosis	Depression
Overweight	Hepatitis	Mental illness	Migraines	UTI's
Other:				

Please list any medications that you are taking (over the counter and prescriptions) and list the dosage (Please be specific)

Medication **Dosage**

____

____

____

Please list any surgeries you have had or CIRCLE no surgeries

____

____

No surgeries or not related to current information

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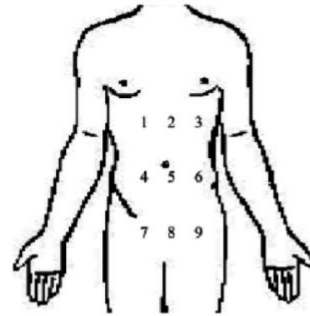
Visceral History

1. Do you experience abdominal pain? If so, please mark the pain location on the picture below.
2. How often do you experience abdominal pain?
   Days/week 0 1-2 3-5 7
3. Is there any connection between this pain and physical effort? Yes No
4. Was the onset of this pain associated with any kind of trauma? Yes No
   If yes, indicate the location on the diagram to the right.
5. Was the onset of this pain associated with any postural strain? Yes No
   (e.g. leaning forward for a long time)
6. Do you experience or have experienced increased bowel sounds and/or flatulence? Yes No
7. Do you experience or have experienced difficulty breathing in connection with this pain? Yes No
8. Do you experience or have experienced back pain? Yes No
9. Do you experience or have experienced groin pain? Yes No
10. Do you experience or have experienced pain in genitalia? Yes No
11. Do you experience or have experienced tingling? Yes No
    If yes, where at? ____
12. What specialists have you visited because of this pain? ________________________
13. How long have you had abdominal pain? __________________________________
14. What treatment have you been on, after diagnosis? __________________________
15. What changes have you noticed after treatment? ____________________________
16. Have you undergone any surgical procedure because of this pain? (indicate operation) ________
    ____
17. If you experience any symptoms not mentioned in this questionnaire, please describe it briefly.
    ____



Urological History

1. How many times do you urinate during the day? _________times per day
2. How often do you wake up to urinate after going to bed? _________times
3. After emptying your bladder do you have the feeling that you have not finished? Yes No
4. Do you experience any leakage of urine? Yes No
5. After you urinate, do you have any dribbling? Yes No
6. Please CIRCLE if you leak urine during the following situations:
   Walking Running Urgency Changing positions (sit→stand)
   Lying Down Exercise Intercourse Straining/lifting Cough/Sneeze/Laugh

Bowel Symptoms

7. How often do you have a bowel movement?: ___ per day ___ per week.
8. Do you strain to go? Yes No
9. Please CIRCLE the bowel symptoms you are experiencing:
   Diarrhea Constipation Incontinence Laxative Use
   Increased Fiber Use Stool Softener Use Leaking Gas (Flatulence)
10. Do you have pain with bowel movements? Yes No
11. Most common stool consistency? (CIRCLE) Liquid Soft Firm Pellets Other

On a scale of 0-10 (0 being no pain, 10 being extreme pain) rate your pain (Circle the number)?

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