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 **CHECK** any of the following health conditions that you now have or had in the past.

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

Other: _____

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

Medication	**Dosage**
_____	_____
_____	_____
_____	_____

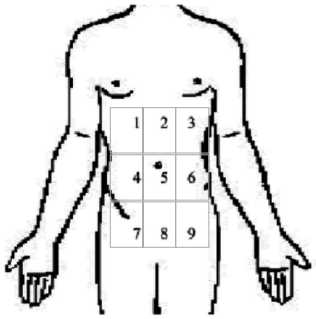
Please list any surgeries you have had or ☐ no surgeries

_____

_____

No surgeries or not related to current information

Physical Therapy & Wellness Center



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? ◯Y ◯N
4. Was the onset of this pain associated with any kind of trauma? ◯Y ◯N
   If yes where? _____
5. Was the onset of this pain associated with any postural strain? ◯Y ◯N (*e.g. leaning forward for a long time*)
6. Do you experience or have experienced increased bowel sounds and/or flatulence? ◯Y ◯N
7. Do you experience or have experienced difficulty breathing in connection with this pain? ◯Y ◯N
8. Do you experience or have experienced back pain? ◯Y ◯N
9. Do you experience or have experienced groin pain? ◯Y ◯N
10. Do you experience or have experienced pain in genitalia? ◯Y ◯N
11. Do you experience or have experienced tingling? ◯Y ◯N 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 **CHECK** 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 **CHECK** 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? (**CHECK**) ☐Liquid ☐Soft ☐Firm ☐Pellets ☐Other

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