



Clear Passage

PHYSICAL THERAPY

MEDICAL HISTORY FORM

(Please Print in Black Ink)

SECTION 1: PERSONAL INFORMATION							
Last name:		First name:		Home Phone:	Cell Phone:	Work Phone:	
Contact Preference: <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Email			Height (Feet, Inches):		Weight (lbs.):	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Email Address:				
Address Line 2:		City:		State:	ZIP Code:		
Occupation:		Ethnicity: <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Latin <input type="checkbox"/> Asian <input type="checkbox"/> African American/Black <input type="checkbox"/> Native American <input type="checkbox"/> Arabic <input type="checkbox"/> Other If other, please specify:					
Treatment Needs: <input type="checkbox"/> Pain <input type="checkbox"/> Infertility <input type="checkbox"/> Obstruction <input type="checkbox"/> Adhesions <input type="checkbox"/> Other If other, please specify:							
SECTION 2: AREAS OF PAIN							
My worst pain area is:							
My usual pain level in this area is (circle one): 0 1 2 3 4 5 6 7 8 9 10 Mild Moderate Severe				Pain is: <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent			
				Pain is: <input type="checkbox"/> Dull Aching <input type="checkbox"/> Sharp Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Tight <input type="checkbox"/> Pressure			
My next worse pain area is:							
My usual pain level in this area is (circle one): 0 1 2 3 4 5 6 7 8 9 10 Mild Moderate Severe				Pain is: <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent			
				Pain is: <input type="checkbox"/> Dull Aching <input type="checkbox"/> Sharp Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Tight <input type="checkbox"/> Pressure			
Other pain areas include:							
My usual pain level in this area is (circle one): 0 1 2 3 4 5 6 7 8 9 10 Mild Moderate Severe				Pain is: <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent			
				Pain is: <input type="checkbox"/> Dull Aching <input type="checkbox"/> Sharp Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Tight <input type="checkbox"/> Pressure			
Because of my pain in these areas, I cannot do the following things:							

Medical History: Please check all that apply

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Pelvic/Abdominal Pain | <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Difficulty Sitting |
| <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Vaginal Infection | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> STD or Herpes | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Allergies/Sinusitis |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> PCOS | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Other |

If other, please specify:

SECTION 3: CONTRAINDICATIONS

Do you have an active infection, hemophilia, or HIV? Yes No

If yes, please explain:

Do you currently have or have you ever had cancer? Yes No

If yes, please explain (date / location / type / size / treatments / stage 1-4 / remission):

SECTION 4: SURGERY AND TRAUMA HISTORY

Genital Mutilation	Surgery to the cervix	Hysterectomy
Laparotomy (open surgery)	Bladder repair	Fractures
Adhesion removal (lysis)	Pelvic Surgery	Episiotomy
Laparoscopy	Tummy Tuck	Fibroid
Appendectomy	Gall Bladder	C-Section
Pins, plates or screws inserted		

PLEASE include dates and explanations for any surgery you have undergone. The above list is for reference.

Car Accidents	Hit on head/back	Falls to tailbone, back, hip
Physical/Sexual Abuse	Radiation therapy	

PLEASE include dates and explanations for any trauma you have undergone. The above list is for reference.

Have you had problems or complications from any surgeries or traumatic injuries? Yes No

If yes, please explain:

List diagnostic tests you've had regarding present or past medical complaints (give dates & diagnosis)

I experience pain with: Intercourse Urination Bowel Movements Erections Other

If other, please explain:

Have you ever been told you have adhesions/scars? Yes No

Were you treated for adhesions/scars? Yes No

If yes, how were you treated?

SECTION 5: FOR FEMALES ONLY (MALES SKIP TO SECTION 7)

Do you currently have any ovarian cyst(s)? Yes No I don't know

If yes, what are present cyst(s) location and size?

Present cyst(s) are Intermittent Chronic Chocolate Gestational

How many pregnancies have you had? (Number / outcome ex. full-term / tubal / miscarriage / abortion / D & C)

Have you ever had an IUD (intrauterine device)? Yes No

Do you presently have an IUD (intrauterine device)? Yes No

During sex, I have decreased Desire (libido) Arousal Lubrication Orgasm

I have pain with intercourse _____% of the time.

Do you experience pain with your menstrual cycle Yes No

If yes, explain (pre-menstrual, period related, ovulatory)

SECTION 6: FOR INFERTILE FEMALES ONLY (MALES SKIP TO SECTION 7)

Hormone Levels: FSH _____ Estrogen _____ Progesterone _____
LH _____ Estradiol _____ Thyroid _____

Are you presently undergoing any treatments for infertility? Yes No
If yes, explain:

Describe past infertility treatments, dates and outcomes:

Tell us what you know about your reproductive system

Fallopian tube (right): Functional Scarred Blocked Removed Unsure

Fallopian tube (left): Functional Scarred Blocked Removed Unsure

Ovaries:

Uterus:

SECTION 7: GOALS FOR THERAPY

My goals for therapy include: (e.g. fertility, pain relief, improved bowel or other functions)

Is there anything else you'd like to ask or we should know?

THANK YOU FOR PROVIDING YOUR INFORMATION.

Please print your medical history form and do one of the following:

- Fax it to us at 352.336.9980
- Scan and Email it to info@clearpassage.com
- Postal mail it to 4421 NW 39th Ave. Suite 2-2, Gainesville, FL 32606