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Home office:

1-352-336-1433 phone  
1-352-336-9980 fax  
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Thank you for your interest in our unique work. Please complete and submit this medical history questionnaire for thorough review by our Therapist Director to determine if our therapy may be appropriate for you. We will contact you to confirm that we have received your questionnaire and again after the review process is complete.

We will postal mail a letter to you advising of our findings and, if you have not yet received it, additional information regarding our services (usually within 7-10 days). This comprehensive introduction package includes our *Guide to Services*, research study information, DVD, and a compilation of quotes about us from local and national press.

Once we advise you that therapy appears appropriate for you, you may schedule your therapy services. Or if you prefer, you may first schedule a 30 minute telephone consultation with our Therapist Director (free of charge) to further discuss your case.

Please note the following:

1. **Include your lifetime history for your entire body**, not just the areas where you now have problems. Falls, traumas, infections, inflammations and surgeries we sustain during our lives can affect distant parts of the body, many years later.
2. **Include any pain you experience**. This can also be important if you will be filing for insurance reimbursement.
3. **Please print your completed questionnaire**. Your answers can not be saved. In case there is an error in receiving your emailed questionnaire, or if you prefer, you may forward your completed questionnaire via fax to 352 336-9980 or postal mail to the address above.

Thank you for your interest in our work. We look forward to helping you reach your goals.

Sincerely,

*The Clear Passage Staff*

The Clear Passage Staff

1-866-222-9437 toll free (US and Canada)

**OFFICE USE ONLY:**

Accept / Decline

Date Intro Sent:

Date Quest Rec'd

Date Reviewed:

By:

**Patient Questionnaire<sup>®</sup>**

Select or Check all appropriate choices, noting all lifetime history & traumas  
Be thorough and answer all questions to the best of your ability

Personal Information		Physician Information	
Name:		Name:	
Address:		Address:	
City/St/Zip:		City/St/Zip:	
Country:		Phone:	Fax:
Home Ph:	Email:		
Cell:	Work Ph:	Contact Preference:	
Date of Birth:	Age:	Height:	Weight:
Marital Status:	Ethnicity (for research):		Profession:
Education:	High School	years	College
			years
			Grad School
			years

**I am interested in treatment for:**

Whether coming for infertility or pain, list all pain in order from worst area to least (including menstrual):

<b>My worst pain area</b> is my					Duration:
<b>My pain level in this area is</b>	Usually:	At Best:			At Worst:
<b>Pain is:</b>	Dull Aching	Sharp Shooting	Burning	Tight	Pressure
<b>Pain began</b>	on (date):				
due to					
<b>This pain began in the</b>					
and spread to the					
<b>Since onset, pain severity has</b>	frequency has		duration has		
<b>This pain increases with:</b>	sitting	standing	bending	lifting	
sexual intercourse	climbing	walking	driving	deep breathing	
housekeeping	coughing	cold	sneezing	rainy weather	
social activities	reaching	Other			
<b>and pain decreases with:</b>	rest	ice	heat	medication	
postural / positional changes	Other				

<b>My next to worst pain area</b> is my					Duration:
<b>My pain level in this area is</b>	Usually:	At Best:			At Worst:
<b>Pain is:</b>	Dull Aching	Sharp Shooting	Burning	Tight	Pressure
<b>Pain began</b>	on (date):				
due to					
<b>This pain began in the</b>					
and spread to the					
<b>Since onset, pain severity has</b>	frequency has		duration has		
<b>This pain increases with:</b>	sitting	standing	bending	lifting	
sexual intercourse	climbing	walking	driving	deep breathing	
housekeeping	coughing	cold	sneezing	rainy weather	
social activities	reaching	Other			
<b>and pain decreases with:</b>	rest	ice	heat	medication	
postural / positional changes	Other				

<b>Other pain areas</b> is my					Duration:
<b>My pain level in this area is</b>	Usually:	At Best:	At Worst:		
<b>Pain is:</b>	Dull Aching	Sharp Shooting	Burning	Tight	Pressure
<b>Pain began</b> due to	on (date):				
<b>This pain began in the</b> and spread to the					
<b>Since onset, pain severity has</b>	frequency has		duration has		
<b>This pain increases with:</b>	sitting	standing	bending	lifting	
sexual intercourse	climbing	walking	driving	deep breathing	
housekeeping	coughing	cold	sneezing	rainy weather	
social activities	reaching	Other			
<b>and pain decreases with:</b>	rest	ice	heat	medication	
postural / positional changes	Other				

<b>Bladder &amp; Bowel</b>	<b>How many times do you usually urinate during the day?</b>			<b>During the night?</b>	
<b>I have:</b>	urinary incontinence (stress -urge)		difficulty initiating urination		
<b>Voiding is often:</b>	incomplete	frequent	painful		
<b>I often have</b>	diarrhea	constipation	bowel incontinence	Other	
I have <b>Bowel movement</b> pain up to	before	during	after		
<b>Urination</b> pain up to	before	during	after		

<b>Sex</b>	<b>I have decreased</b> desire (libido)	arousal	lubrication	satisfaction	
<b>My orgasms</b> are	normal	decreased	infrequent	absent	
<b>I often feel too dry during intercourse</b>					
<b>I experience pain with intercourse</b>			of the time		
<b>Initial penetration pain</b>	worst	average	<b>Deep penetration pain</b>	worst	average
<b>I experience painful sex in:</b>	all positions		missionary	when I am on top	
	when I am prone		when I am on hands and knees		

<b>Menstruation</b>	<b>I experience pain with my menstrual cycle?</b>				
<b>Pain before my period</b>	worst	average	for	days	Location:
<b>Pain during my period</b>	worst	average	for	days	Location:
<b>Pain during ovulation</b>	worst	average	for	days	Location:
<b>I take these medications for this pain:</b>					
<b>Age at first menstrual period?</b>	years old		<b>Frequency of your periods?</b>	every	days
<b>How long do your periods last?</b>	days		<b>Date of your last menstrual period?</b>		

<b>Function</b>	<b>Rate your overall daily functional level:</b>		Good day	Bad day	Average day
<b>Because of my symptoms or condition, I cannot do these things I would like to do:</b>					
<b>Upon arising, I am:</b>	stiff	sore	aching	tight	fine
<b>Once I move around, I feel:</b>					
<b>By the end of the day, I feel:</b>			<b>At night, my pain</b>		
<b>Are you experiencing any weakness?</b>			Where?		
<b>Are you experiencing tingling or pins &amp; needles sensations?</b>			Where?		
<b>Are you experiencing any numbness?</b>			Where?		

<b>My goals for therapy include:</b> (e.g., fertility, pain relief, increased function)
<b>Primary Goal(s)</b>
<b>Secondary Goal(s)</b>
<b>Other Goal(s)</b>

<b>Medical History</b>	(select letters for: <b>Never, Once, Sometimes, Frequent, Always</b> )	
bladder infection	digestive problems	polyps
interstitial cystitis	constipation	arthritis
incontinence	intestinal problems	neurological disorder
kidney infection	hemorrhoids	headaches
kidney stones	painful intercourse	lupus
vaginal infection	difficulty sitting	fibromyalgia
infertility	high blood pressure	chronic fatigue
pelvic/abdominal adhesions	diabetes	physical disability
pelvic pain	cancer	allergies/ sinusitis
abdominal pain	cardiovascular disease	mononucleosis
hormonal problems	thyroid problems	depression
endometriosis	liver disorder	cold hands/feet
pelvic inflammatory disease (PID)	gall stones	anxiety
uterine fibroids	STD or herpes	
<b>Do you drink alcohol?</b>	<b>How many drinks do you have a day</b>	<i>a week</i>
<b>Do you smoke cigarettes?</b>	<b>How many <i>cigarettes</i> do you smoke daily?</b>	

<b>Contraindications</b>	<b>Do you have an active infection?</b>	Where?		
<b>I presently have:</b>	abnormal cysts	cancer	hemophilia	HIV
<b>I have had:</b>	abnormal cysts	cancer	hemophilia	HIV
<b>Explain:</b>				

<b>This Section – Females Only</b>
<b>Do you currently have an endometrioma?</b>
<b>Do you currently have ovarian cyst(s)?</b>
<b>Present cyst(s):</b> Location and size: <b>L ovary</b> <b>R Ovary</b>
<b>Prior cyst(s):</b> Location and size: <b>L ovary</b> <b>R Ovary</b>
<b>Have you ever had an IUD?</b> Type? For how many years?
<b>How many pregnancies have you had</b> (dates)?
<b>How many were full-term</b> (delivery dates)?
Birth weights of babies:
<b>How many tubal pregnancies</b> (ectopics) / (dates)?
<b>Other labor / delivery complications</b> (dates)?
<b>How many abortions</b> (dates)?
<b>How many miscarriages</b> (dates)?



**Infertile Women Only**

(this entire section)

Please answer to the best of your knowledge

**How long have you had unprotected intercourse, without a full-term pregnancy?** \_\_\_\_\_ years**How often do you have sexual intercourse per week?****Do you know when you're ovulating?****How has your ovulation been confirmed?** basal body temp home ovulation test Ultrasound  
progesterone levels Other**Your hormone levels:**

Estrogen: Estradiol: FSH: Progesterone: LH: Thyroid:

**Has your partner had a semen analysis?**

Sperm motility: Sperm count: Testosterone level:

**Identify any of these infertility treatments you have had:**

Clomid \_\_\_\_\_ times. Dates: \_\_\_\_\_

Explain: \_\_\_\_\_

Hormone treatment \_\_\_\_\_ months. Dates: \_\_\_\_\_

Explain: \_\_\_\_\_

Intrauterine insemination \_\_\_\_\_ times. Dates: \_\_\_\_\_

Explain: \_\_\_\_\_

Surgery to open tubes \_\_\_\_\_ times. Dates: \_\_\_\_\_

Explain: \_\_\_\_\_

In vitro fertilization \_\_\_\_\_ times. Dates: \_\_\_\_\_

Explain: \_\_\_\_\_

**GIFT or other ART? If so, what?****Are you presently undergoing any treatment for infertility? What?****Date and description of your last medical efforts to become pregnant? Date:**

Description: \_\_\_\_\_

**Could you be pregnant now?****Tell us what you know about your reproductive system: (check all appropriate choices)**

Fallopian tubes: Describe:

Left: functional scarred blocked removed unsure

Right: functional scarred blocked removed unsure

Ovaries: Describe:

Left: functional scarred blocked removed unsure

Right: functional scarred blocked removed unsure

Fimbriae: Describe:

Left: functional scarred blocked removed unsure

Right: functional scarred blocked removed unsure

**My doctor diagnosed the above by:** HSG laparoscopy hysteroscopy chromotubation (dye) unsure**Have you ever been told you have pelvic adhesions?**

How did your physician diagnose the adhesions? HSG laparoscopy unsure

Were you treated for adhesions? How?

**Have you ever been told you have endometriosis?**

How did your physician diagnose the endometriosis? HSG laparoscopy unsure

Were you treated for endometriosis? How?

**Have you ever been told you have PID (pelvic inflammatory disease)?**

How did your physician diagnose the PID? physical exam cultures unsure

Were you treated for PID? How?

**Do you have a sense of what you need?**

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

**Where did you hear about Clear Passage?** (please fill in all that apply)

Web Search Engine? Search term used?
Website?
AFA
INCIID
RESOLVE
Chat room
Wikipedia
Magazine article
Magazine ad
Newsletter article
Newsletter ad
Newspaper article
TV News
Healthcare Prof'l
Symposium?
Referral from:
Other:

**Please print your completed questionnaire.**

Clear Passage Therapies maintains strict confidentiality of all information submitted to us via this form. However, we cannot be responsible for information that is intercepted in the process of sending and receiving data via the Internet. By submitting your information via email, you are acknowledging that you understand your personal and health information may not be secure. You are further acknowledging that you are submitting your information at your own risk and that Clear Passage Therapies cannot be held responsible or liable for any unauthorized use, disclosure, copying or distribution of your information by any unintended recipients of this email.

If you do not agree to this risk, you may print your completed questionnaire now and either fax to us at 352-336-9980 or mail to us at 4421 NW 39<sup>th</sup> Ave, Suite 2-2, Gainesville, FL 32606.