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Thank you for your interest in our unique work. Please complete and submit this Medical History form. To maintain your privacy, we do not email our findings. We will review your form thoroughly, call you, and offer to schedule a 30 minute therapist consultation, at no charge.

We will also mail our findings to you with an information package. This will include detailed information about therapy for your condition, pricing, and scheduling to help you determine if our therapy fits your needs. We can schedule treatment once the therapist reviews your Medical History.

Instructions for completing this form:

1. Include the lifetime history of 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 is especially important if you will be filing for insurance reimbursement.
3. Leave this document open on your computer until you have submitted or printed it. Closing it deletes your information.
4. Print your completed Medical History. If you prefer, you may fax your printed Medical History to 352 336-9980 or post it by 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

1.352.336.1433

OFFICE USE ONLY:

Accept / Decline

Date Intro Sent:

Date Quest Rec'd

Date Reviewed:

By:

Patient Questionnaire[©]

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



Section 1: Personal Information		Physician Information	
Name:		Name:	
Address:		Address:	
City/St/Zip:		City/St/Zip:	
Country:		Phone:	Fax:
Home Ph:	Email:	Sex:	
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 pain, infertility, obstruction, or dysfunction, please list all pain in order from worst area to least:

Section 2: Areas of Pain				
My worst pain area	is my			Duration:
My pain level in this area is	Usually:	At Best:		At Worst:
Pain is:	Dull Aching	Sharp Shooting	Burning	Tight Pressure
Pain began	on (date):			
due to				
This pain began in the				
and spread to the				
Since onset, pain severity has		frequency has		duration has
This pain increases with:	sitting	standing	bending	lifting
sexual intercourse	climbing	walking	driving	deep breathing
housekeeping	coughing	cold	sneezing	rainy weather
social activities	reaching	Other		
and pain decreases with:	rest	ice	heat	medication
postural / positional changes		Other		
My next to worst pain area	is my			Duration:
My pain level in this area is	Usually:	At Best:		At Worst:
Pain is:	Dull Aching	Sharp Shooting	Burning	Tight Pressure
Pain began	on (date):			
due to				
This pain began in the				
and spread to the				
Since onset, pain severity has		frequency has		duration has
This pain increases with:	sitting	standing	bending	lifting
sexual intercourse	climbing	walking	driving	deep breathing
housekeeping	coughing	cold	sneezing	rainy weather
social activities	reaching	Other		
and pain decreases with:	rest	ice	heat	medication
postural / positional changes		Other		

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

Section 3: Functionality

Bladder & Bowel	How many times do you usually urinate during the day?		During the night?	
I have:	urinary incontinence (stress -urge)		difficulty initiating urination	
Voiding is often:	incomplete	frequent	painful	
I often have	diarrhea	constipation	bowel incontinence	Other
I have Bowel movement pain up to	before	during	after	
Urination pain up to	before	during	after	
Function	Rate your overall daily functional level:		Good day	Bad day Average day
Because of my symptoms or condition, I cannot do these things I would like to do:				
Upon arising, I am:	stiff	sore	aching	tight fine
Once I move around, I feel:				
By the end of the day, I feel:		At night, my pain		
Are you experiencing any weakness?		Where?		
Are you experiencing tingling or pins & needles sensations?		Where?		
Are you experiencing any numbness?		Where?		

Section 4: Medical History

(select letters for: **Never, Once, Sometimes, Frequent, Always**)

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	lymphedema

Do you drink alcohol?	How many drinks do you have a day	a week
Do you smoke cigarettes?	How many cigarettes do you smoke daily?	

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

Surgery & Trauma History			
Surgery	Date	Surgery	Date
Laparoscopy		Laparotomy	
Appendectomy		Adhesion removal (lysis)	
Surgery to cervix		Abortion	
Bladder repair		D & C	
Abdominal surgery		C – Section	
Pelvic surgery, fibroid		Hysterectomy	
Tummy tuck		Pins, plates or screws	
Hysteroscopy		Gall bladder removal	
Episiotomy		Genital reconstruction	
Genital mutilation/circumcision		Bowel Obstruction Surgery	
Trauma	Date	Trauma	Date
Car accidents		Falls onto tailbone, back, hip	
Hit on head		Falls (from horse, bike, etc.)	
Hit on back		Low back / hip injury	
Physical or sexual abuse		Radiation therapy	

Why were surgeries performed?

Have you had problems or complications from any surgeries or traumatic injuries? Explain:

Any broken bones? What and when?

List any additional test you've had regarding present or past medical complaints, the test results or your doctor's medical diagnosis	
Date:	Details:
Date:	Details:
Date:	Details:
Date:	Details:

Section 5: Lifestyle and Social Factors

What is your usual stress level on a scale of 1-10, 1 is low and 10 is high			
Have you had recent major changes in your daily life?		diet	job
death in family	medication	other	relationships
How many caffeinated drinks do you drink daily?			
Do you sleep well at night?	I have trouble:	falling asleep	remaining asleep
Do you exercise regularly?	Hours per week:		awaken often
What exercise(s)?			
Do you spend more than 20 hours per week combined at a desk, computer and vehicle?			
Do you fly more than 8 hours a month?			
Hours per day you spend outdoors daily (average)?			
What medications and nutritional supplements are you taking? (Name, dosage and frequency for all)			

Section 6: For Females Only (male patients may skip to section 9)

Do you currently have an endometrioma?			
Do you currently have ovarian cyst(s)?			
Present cyst(s):	Location and size:	L ovary	R Ovary
Prior cyst(s):	Location and size:	L ovary	R Ovary
Have you ever had an IUD?	Type?		For how many years?
How many pregnancies have you had (dates)?			
How many were full-term (delivery dates)?			
Birth weights of babies:			
How many tubal pregnancies (ectopics) / (dates)?			
Other labor / delivery complications (dates)?			
How many abortions (dates)?			
How many miscarriages (dates)?			
Sex	I have decreased desire (libido)	arousal	lubrication
My orgasms are	normal	decreased	infrequent
I often feel too dry during intercourse			
I experience pain with intercourse			of the time
Initial penetration pain	worst	average	Deep penetration pain
I experience painful sex in:	all positions	missionary	when I am on top
	when I am prone	when I am on hands and knees	
Menstruation	I experience pain with my menstrual cycle?		
Pain before my period	worst	average	for days Location:
Pain during my period	worst	average	for days Location:
Pain during ovulation	worst	average	for days Location:
I take these medications for this pain:			
Age at first menstrual period?	years old	Frequency of your periods?	every days
How long do your periods last?	days	Date of your last menstrual period?	

Section 7: For Infertile Women Only

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

Has your partner had a semen analysis? Sperm count:
Sperm motility: 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?

Web Search Engine:
Search term used:
Website:
RESOLVE:
Newspaper Article:
Magazine article:
Newsletter article:
<i>Miracle Moms</i> book:
eBook:
Radio:
TV:
Facebook/Twitter:
YouTube video:
Blog/Forum/Message Board:
Podcast:
Healthcare Professional:
Conference/Symposium:
Referral from:
Other:

Please print your completed Medical History now.

If you have trouble submitting this form online,
Please send it to us by:

Fax: 352.336.9980 USA
Mail: 4421 NW 39th Ave., 2-2, Gainesville, FL USA
Scan, then email: info@clearpassage.com

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