
National Headquarters
4421 NW 39th Ave, Suite 2-2
Gainesville, Florida 32606, USA
www.clearpassage.com

1.352.336.1433 phone
1.352.336.9980 fax
info@clearpassage.com

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. You will need to leave the document open on your computer until you have completed all questions, and print or email it. Closing it sooner will delete your information and you will have to start over.
4. **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

1.352.336.1433

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?

Section 10: Where did you hear about us?

(please fill in all that apply)

Web Search Engine:

Search term used:

Website:

RESOLVE:

Newspaper Article:

Magazine article:

Newsletter article:

Miracle Moms book:

eBook:

Radio:

TV:

Facebook/Twitter:

YouTube video:

Blog/Forum/Message Board:

Podcast:

Healthcare Professional:

Conference/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 39th Ave, Suite 2-2, Gainesville, FL 32606.