

**OFFICE USE ONLY: Accept / Decline**

Date Intro Sent: \_\_\_\_\_

Date Quest Rec'd: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

By: \_\_\_\_\_

**Medical History Form ● Clear Passage Physical Therapy®**

**Please use black ink. Print rather than using cursive, noting lifetime medical history & traumas. Circle choices *in italics*. Fax or email completed form to us per instructions on the last page.**

Name \_\_\_\_\_ Physician \_\_\_\_\_

Home address \_\_\_\_\_ Address \_\_\_\_\_

City/state/zip \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home phone \_\_\_\_\_ MD's Phone \_\_\_\_\_

Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Fax \_\_\_\_\_

Your email address \_\_\_\_\_ **Contact preference:** home / work / cell / e-mail

Age \_\_\_\_\_ Date of birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Profession \_\_\_\_\_

Marital status: *M / S / D / W* Ethnicity: (for research) *Cauc / AfroAmer / Latin / Asian / NatAmer / Arabic / Other* \_\_\_\_\_

Tody's date: \_\_\_\_\_ Education: High school \_\_\_\_\_ years College \_\_\_\_\_ years Graduate school \_\_\_\_\_ years

**I AM INTERESTED IN TREATMENT FOR:**  **PAIN**  **INFERTILITY**  **OBSTRUCTION**  **ADHESIONS**

**OTHER** \_\_\_\_\_

**My worst pain area is my** \_\_\_\_\_ **Duration:** \_\_\_\_\_

My usual pain in this area is (none) 0 1 2 3 4 5 6 7 8 9 10 (severe) Best:# \_\_\_\_\_ Worst: # \_\_\_\_\_

My pain in this area is *constant / intermittent / dull aching / sharp shooting / burning / tight / pressure /* \_\_\_\_\_

**This pain began** *gradually / suddenly* on (date): \_\_\_\_\_ **Due to** \_\_\_\_\_

**This pain began in the** \_\_\_\_\_ **and spread to the** \_\_\_\_\_

**Since onset, this pain has** *increased / decreased / stayed the same* in severity / frequency / duration.

**This pain increases with:** *lifting / sitting / standing / walking / bending / climbing / driving / reaching / housekeeping / social activities / cold / rainy weather / sneezing / deep breathing / coughing /* \_\_\_\_\_

**and decreases with:** *rest / ice / heat / postural or positional changes / medication /* \_\_\_\_\_

**My next to worst pain area is my** \_\_\_\_\_ **Duration:** \_\_\_\_\_

My usual pain in this area is (none) 0 1 2 3 4 5 6 7 8 9 10 (severe) Best:# \_\_\_\_\_ Worst: # \_\_\_\_\_

My pain in this area is *constant / intermittent / dull aching / sharp shooting / burning / tight / pressure /* \_\_\_\_\_

**This pain began** *gradually / suddenly* on (date): \_\_\_\_\_ **Due to** \_\_\_\_\_

**This pain began in the** \_\_\_\_\_ **and spread to the** \_\_\_\_\_

**Since onset, this pain has** *increased / decreased / stayed the same* in severity / frequency / duration.

**This pain increases with:** *lifting / sitting / standing / walking / bending / climbing / driving / reaching / housekeeping / social activities / cold / rainy weather / sneezing / deep breathing / coughing /* \_\_\_\_\_

**and decreases with:** *rest / ice / heat / postural or positional changes / medication /* \_\_\_\_\_

**Other pain areas include:** \_\_\_\_\_ **Duration:** \_\_\_\_\_

My usual pain in this area is (none) 0 1 2 3 4 5 6 7 8 9 10 (severe) Best:# \_\_\_\_\_ Worst: # \_\_\_\_\_

My pain in this area is *constant / intermittent / dull aching / sharp shooting / burning / tight / pressure* \_\_\_\_\_

**This pain began** *gradually / suddenly* on (date): \_\_\_\_\_ **Due to** \_\_\_\_\_

**This pain began in the** \_\_\_\_\_ **and spread to the** \_\_\_\_\_

Since onset, this pain has *increased / decreased / stayed the same* in severity / frequency / duration.

This pain increases with: *lifting / sitting / standing / walking / bending / climbing / driving / reaching / housekeeping / social activities / cold / rainy weather / sneezing / deep breathing / coughing /* \_\_\_\_\_

and decreases with: *rest / ice / heat / postural or positional changes / medication /* \_\_\_\_\_

**Bladder and 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 /* \_\_\_\_\_

I have **Bowel movement pain** up to # \_\_\_/10 *before / during / after* **Urination pain** up to # \_\_\_/10 *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: *better / worse / the same*

By the end of the day, I feel: *better / worse / the same*

At night, my pain: *increases / decreases / remains the same*

Are you experiencing any weakness? Yes/No Where? \_\_\_\_\_

Are you experiencing tingling or pins & needles sensation? Yes/No Where? \_\_\_\_\_

Are you experiencing any numbness? Yes/No Where? \_\_\_\_\_

**Medical History** (please circle letters for: Never, Once, Sometimes, Frequent, Always)

bladder infection	N-O-S-F-A	digestive problems	N-O-S-F-A	polyps	N-O-S-F-A
interstitial cystitis	N-O-S-F-A	constipation	N-O-S-F-A	arthritis	N-O-S-F-A
incontinence	N-O-S-F-A	intestinal problems	N-O-S-F-A	neurological disorder	N-O-S-F-A
kidney infection	N-O-S-F-A	hemorrhoids	N-O-S-F-A	headaches	N-O-S-F-A
kidney stones	N-O-S-F-A	painful intercourse	N-O-S-F-A	lupus	N-O-S-F-A
vaginal infection	N-O-S-F-A	difficulty sitting	N-O-S-F-A	fibromyalgia	N-O-S-F-A
infertility	N-O-S-F-A	high blood pressure	N-O-S-F-A	chronic fatigue	N-O-S-F-A
pelvic, abdominal adhesions	N-O-S-F-A	diabetes	N-O-S-F-A	physical disability	N-O-S-F-A
pelvic pain	N-O-S-F-A	cancer	N-O-S-F-A	allergies/ sinusitis	N-O-S-F-A
abdominal pain	N-O-S-F-A	cardiovascular disease	N-O-S-F-A	mononucleosis	N-O-S-F-A
hormonal problems	N-O-S-F-A	thyroid problems	N-O-S-F-A	depression	N-O-S-F-A
endometriosis	N-O-S-F-A	liver disorder	N-O-S-F-A	cold hands/feet	N-O-S-F-A
pelvic inflammatory disease (PID)	N-O-S-F-A	gall stones	N-O-S-F-A	anxiety	N-O-S-F-A
lymphedema	N-O-S-F-A	uterine fibroids	N-O-S-F-A	STD or herpes	N-O-S-F-A

Do you drink alcohol? . . . . . Y/N How many drinks do you have a day \_\_\_\_\_ week \_\_\_\_\_

Do you smoke cigarettes? . . . . . Y/N How many cigarettes do you smoke daily? \_\_\_\_\_

**Contraindications** Do you have an active infection? Y/N Where? \_\_\_\_\_  
 Circle any condition you presently have: abnormal cysts / endometrioma / cancer / hemophilia / HIV  
 Circle any condition you have ever had: abnormal cysts / endometrioma / cancer / hemophilia / HIV  
 Explain: \_\_\_\_\_

**Surgery & Trauma History** (with approximate dates)

Surgery	Date	Surgery	Trauma
Laparoscopy		Laparotomy (open surgery)	Car accidents
Appendectomy		Adhesion removal (lysis)	Falls onto tailbone, back, hip
Surgery to the cervix		Abortion, D&C (circle)	Falls (from horse, bike, etc.)
Bladder repair		C- section, episiotomy (circle)	Hit on the head
Abdominal surgery		Hysterectomy (total / partial)	Hit on the back
Pelvic surgery, fibroid (circle)		Pins, plates or screws inserted	Low back / hip injury
Tummy tuck, gall bladder removal (circle)		Hysteroscopy w/ w/o dye	Radiation therapy
Genital mutilation/circumcision (age)		Genital reconstruction (age)	Physical or sexual abuse

**Additional Surgeries & Traumas not listed:** \_\_\_\_\_

**Why were surgeries performed?** \_\_\_\_\_

**Have you had problems or complications from any surgeries or traumatic injuries?** . . . . . yes / no / unsure  
 Explain: \_\_\_\_\_

**Any broken bones? Yes/No. What and when?** \_\_\_\_\_

**List all additional tests** you've had regarding present or past medical complaints, the results or your doctor's diagnosis  
 \_\_\_\_\_ (date)  
 \_\_\_\_\_ (date)  
 \_\_\_\_\_ (date)  
 \_\_\_\_\_ (date)

<b>This Section: Males Only</b>	
I experience pain with: <i>intercourse / erections / other:</i> _____	
I have decreased: <i>desire (libido) / arousal / satisfaction</i>	<b>My orgasms are:</b> <i>normal / decreased / absent</i>
Have you ever been told you have adhesions? <i>Yes / No</i>	<b>Were you treated for adhesions?</b> <i>Yes / No</i>
How were you treated? _____	

**Lifestyle and Social Factors**

Circle your usual stress level on a scale of 1-10, 1 is low and 10 is high: ..... 1 2 3 4 5 6 7 8 9 10

Have you had recent major changes in your daily life ? (relationship, death in family, medication, diet, job)

Other major changes? \_\_\_\_\_

I have trouble falling asleep / remaining asleep / I awaken often

Do you exercise regularly? yes / no Hours per week: \_\_\_\_\_

What exercise(s)? \_\_\_\_\_

Do you spend more than 20 hours per week combined at a desk, computer and vehicle? ..... yes/ no/ unsure

Do you fly more than 8 hours a month? ..... yes/ no/ unsure

Hours per day you spend outdoors daily (average)? ..... 0-2, 3-5, 6-8, more than 8

What medications and nutritional supplements are you taking? (Name, dosage and frequency for all)

**This Section: Females Only**

Do you currently have an endometrioma? Yes / No / I don't know

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

Present cyst(s): Location & size: L ovary \_\_\_\_\_ mm/cm R ovary \_\_\_\_\_ mm/cm Intermittent - Chronic - Chocolate - Gestational

Prior cysts: Location & size: L ovary \_\_\_\_\_ mm/cm R ovary \_\_\_\_\_ mm/cm Intermittent - Chronic - Chocolate - Gestational

Have you ever had an IUD? yes / no Type? \_\_\_\_\_ For how many years? \_\_\_\_\_

How many pregnancies have you had (dates)? \_\_\_\_\_

How many were full-term (delivery dates)? \_\_\_\_\_

How many tubal pregnancies (ectopics) with dates? \_\_\_\_\_

Other pregnancy / delivery complications with dates \_\_\_\_\_

How many abortions / (dates)? \_\_\_\_\_

How many miscarriages / (dates)? \_\_\_\_\_

**Sex** I have decreased: desire (libido) / arousal / lubrication / satisfaction When? rarely / frequently / always

My orgasms are normal / decreased / infrequent / absent I often feel too dry during intercourse yes / no

I experience pain with intercourse 25% / 50% / 75% / 100% of the time

Pain with initial penetration the worst is rated as # \_\_\_\_\_ / 10 the average is rated as # \_\_\_\_\_ / 10

Pain with deep penetration the worst is rated as # \_\_\_\_\_ / 10 the average is rated as # \_\_\_\_\_ / 10

I experience painful sex in: all positions / missionary / when I am on top / when I am prone / when I am on hands & knees

**Menstruation** I experience pain with my menstrual cycle? yes / no

Before my period my worst pain is # \_\_\_\_\_ / 10, my average pain is # \_\_\_\_\_ / 10 for \_\_\_\_\_ days Location: L / R / both side(s)

During my period my worst pain is # \_\_\_\_\_ / 10, my average pain is # \_\_\_\_\_ / 10 for \_\_\_\_\_ days Location: L / R / both side(s)

During ovulation my worst pain is # \_\_\_\_\_ / 10, my average pain is # \_\_\_\_\_ / 10 for \_\_\_\_\_ days Location: L / R / both side(s)

I (sometimes / always) take these medications for this pain: \_\_\_\_\_

Age (in years) at first menstrual period \_\_\_\_\_ Frequency of your periods (in days): every \_\_\_\_\_ days

How long do your periods last (in days)? \_\_\_\_\_ Date of your last menstrual period? \_\_\_\_\_

**This Page: Infertile Women Only**

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? ..... 1 time, 2 - 3 times, 4 - 5 times, 6 - 7 times  
Do you know when you're ovulating? ..... never, sometimes, frequently, always  
How has your ovulation been confirmed?(circle) ..... basal body temperature, home ovulation test  
ultrasound, progesterone levels, other \_\_\_\_\_

Your hormone levels: FSH: \_\_\_\_\_ LH: \_\_\_\_\_ Estrogen: \_\_\_\_\_ Estradiol: \_\_\_\_\_ Progesterone: \_\_\_\_\_ Thyroid: \_\_\_\_\_  
Has your partner had a semen analysis? . . . Y/N Sperm count: \_\_\_\_\_ normal / abnormal  
Sperm motility: \_\_\_\_\_ normal / abnormal Testosterone level: \_\_\_\_\_ high / normal / low

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

Ovarian stimulating drugs \_\_\_\_\_ times. Dates \_\_\_\_\_ successful / unsuccessful / mixed

Explain \_\_\_\_\_

Hormone treatment \_\_\_\_\_ months. Dates \_\_\_\_\_ successful / unsuccessful / mixed

Explain \_\_\_\_\_

Intrauterine insemination \_\_\_\_\_ times. Dates \_\_\_\_\_ successful / unsuccessful / mixed

Explain \_\_\_\_\_

Surgery to open tubes \_\_\_\_\_ times. Dates \_\_\_\_\_ successful / unsuccessful / mixed

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

In vitro fertilization \_\_\_\_\_ times. Dates \_\_\_\_\_ successful / unsuccessful / mixed

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

Are you presently undergoing any treatment for infertility? yes / no / unsure What? \_\_\_\_\_

Date and description of your last medical efforts to become pregnant? Date \_\_\_\_\_

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

**Tell us what you know about your reproductive system: (circle all appropriate choices)**

Fallopian tubes: Left: functional / scarred / blocked / removed / unsure Right: functional / scarred / blocked / removed / unsure

Describe: \_\_\_\_\_

Ovaries: Left: functional / adhered / impaired / removed / unsure Right: functional / adhered / impaired / removed / unsure

Describe: \_\_\_\_\_

Fimbriae: Left: functional / adhered / impaired / removed / unsure Right: functional / adhered / impaired / removed / unsure

Describe: \_\_\_\_\_

My doctor diagnosed the above by: \_\_\_\_\_ HSG / laparoscopy / hysteroscopy / chromotubation (dye) / unsure

Have you ever been told you have pelvic adhesions? ..... yes / no / unsure

How did your physician diagnose the adhesions? ..... HSG / laparoscopy / unsure

Were you treated for adhesions? yes / no / unsure. How? \_\_\_\_\_

Have you ever been told you have endometriosis? ..... yes / no / unsure

How did your physician diagnose the endometriosis? ..... HSG / laparoscopy

Were you treated for endometriosis? yes / no / unsure How? \_\_\_\_\_

Have you ever been told you have PID? (pelvic inflammatory disease) ..... yes / no / unsure

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

Were you treated for PID? yes / no / unsure How? \_\_\_\_\_

**Mark your areas of pain on the figures below, as follows:**

**//// Numbness**

**XXXX Severe Pain**

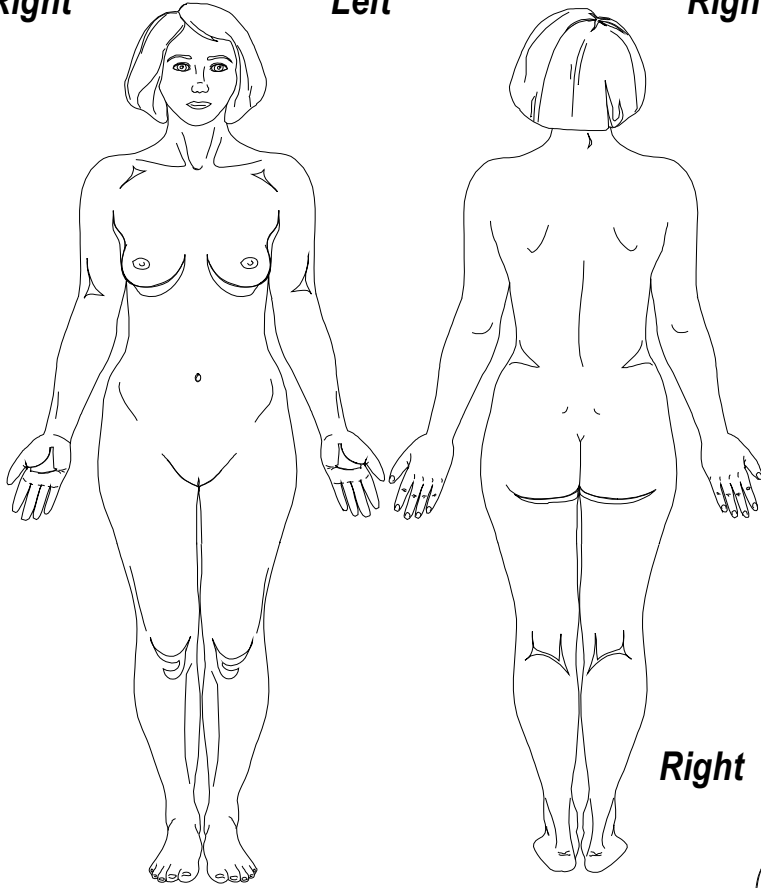
**OOOO Moderate Pain**

**→ Shooting Pain**

**Right**

**Left**

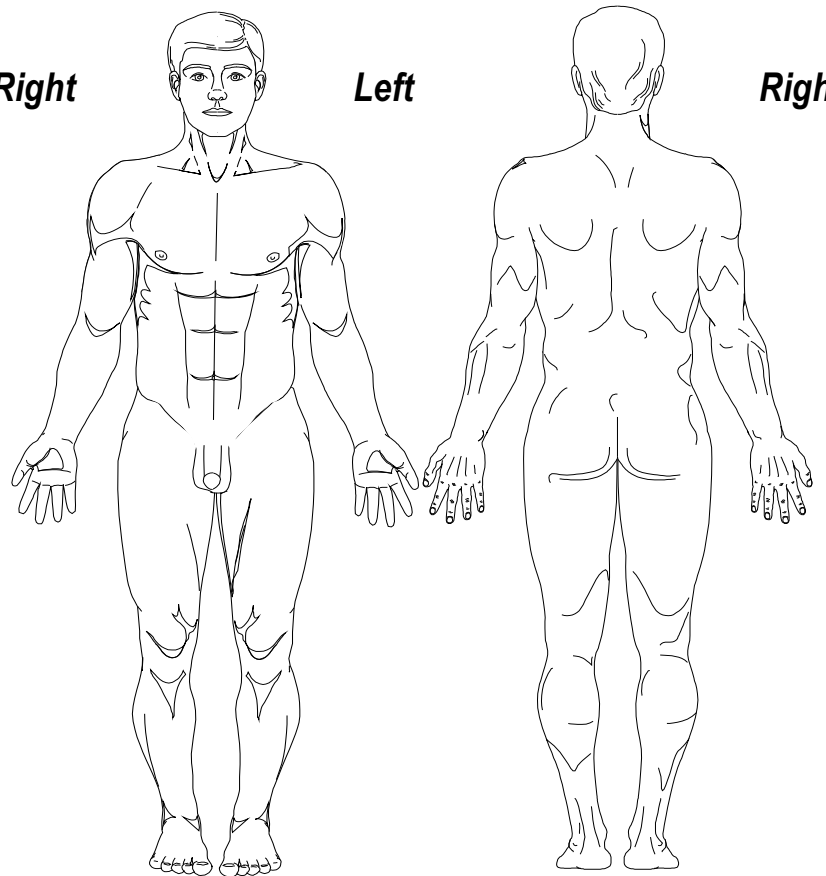
**Right**



**Right**

**Left**

**Right**



**Goals**

My goals for therapy include: (e.g., fertility, pain relief, increased function)

Primary Goal(s) \_\_\_\_\_  
\_\_\_\_\_

Secondary Goal(s) \_\_\_\_\_  
\_\_\_\_\_

Other Goal(s) \_\_\_\_\_  
\_\_\_\_\_

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

**Where did you learn about Clear Passage?**

Please circle all that apply

- Web Search (Google, Bing, etc.)
- Website
- Web Video (YouTube, Vimeo . . .)
- Blog, Forum, Message Board
- Facebook
- Twitter
- Other: \_\_\_\_\_

- eBook
- Podcast
- Conference
- Miracle Moms* book
- Other book
- Radio

- Friend
- Healthcare provider
- Newspaper
- Magazine
- TV

**Once you've completed this form**

Keep a copy for your records, then either:

**Fax it to:**

352.336.9980 [USA, country code is: 1]

or

**Mail it to:**

Clear Passage Physical Therapy  
National Headquarters  
4421 NW 39<sup>th</sup> Ave., Suite 2-2  
Gainesville, FL 32606

**What happens next?**

Within 7-10 days of receiving your completed questionnaire, we will call you to advise whether therapy appears appropriate for you. If it does, we will offer you a 30 minute telephone consultation with a therapist (at no charge) to discuss your case and answer any questions you may have about treatment. We will also postal mail you with our full Introduction Package, our goals for your therapy and scheduling information.

**To schedule therapy**

Call 352.336.1433