

RE-EVALUATION PATIENT QUESTIONNAIRE

Please answer all questions to the best of your ability. Check all that apply where appropriate.
 Return by fax to: (352) 336-9980 - or mail to: 4421 NW 39th Ave, Ste 2-2, Gainesville, FL 32606
 Call to schedule a phone consultation with a therapist.(no charge)



Name: _____ Email: _____ Date: _____

Dates previously seen at CPT? _____

Best numbers and times to talk by phone: _____

Changes you noticed after therapy:

Why are you returning to therapy? *Pain* *Infertility* _____

Please list all current pain complaints, from worst to least:

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 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				
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 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				

Current Pain complaints (continued)

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				
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		
Sex	I have decreased desire (libido)	arousal	lubrication	satisfaction	
My orgasms are	normal	decreased	infrequent	absent	
I often feel too dry during intercourse					
I experience pain with intercourse of the time					
Initial penetration pain	worst	average	Deep penetration pain	worst	average
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?		
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?					

My goals for therapy include:	(e.g., fertility, pain relief, increased function)
Primary Goal(s)	
Secondary Goal(s)	
Other Goal(s)	
Changes since my last visit:	
Medical History:	
Surgical History:	
Reproductive History:	
Diagnostic Tests performed:	
Current Medications:	
Have you received any <i>physical therapy</i> <i>chiropractic</i> <i>acupuncture</i> since last attending CPT?	

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.