OFFICE USE ONLY: Accept / Qualified / Decline

Date Intro Sent: Date MHF 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 *Mr / Mrs / Ms /* _____

Home address _____ City _____

State _____ Zip _____ Country (if outside US) _____

Home phone _____ Work phone _____

Cell phone _____ Fax _____

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

Age____ **Date of birth**_____ **Height**____ft____in **Weight**____lbs **Profession**_____

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

Today's date:_____ **Education:** High school_____ years / College_____ years / Graduate school _____ years

I AM INTERESTED IN TREATMENT FOR: ☐ PAIN ☐ INFERTILITY ☐ BOWEL OBSTRUCTION
☐ POST SURGICAL ADHESIONS ☐ SEXUAL DYSFUNCTION ☐ HORMONAL PROBLEMS
☐ OTHER_____

My worst pain area is my _____ Duration:_____

My pain in this area is *constant / intermittent / dull aching / sharp shooting / burning / tightness / pressure / cramping* / _____

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

This pain began *gradually / suddenly* in (date): _____ **Due to** _____

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 / sexual intercourse / housekeeping / social activities / cold / rainy weather / sneezing / deep breathing / coughing* / _____

and decreases with: *nothing decreases this pain / medication / postural or positional changes / heat / ice / rest*

My next to worst pain area is my _____ Duration:_____

My pain in this area is *constant / intermittent / dull aching / sharp shooting / burning / tightness / pressure / cramping* / _____

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

This pain began *gradually / suddenly* in (date): _____ **Due to** _____

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 / sexual intercourse / housekeeping / social activities / cold / rainy weather / sneezing / deep breathing / coughing* / _____

and decreases with: *nothing decreases this pain / medication / postural or positional changes / heat / ice / rest.*

Other pain areas include: _____ Duration:_____

My pain in this area is *constant / intermittent / dull aching / sharp shooting / burning / tightness / pressure / cramping* / _____

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

This pain began *gradually / suddenly* in (date): _____ **Due to** _____

_____

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 / sexual intercourse / housekeeping / social activities / cold / rainy weather / sneezing / deep breathing / coughing* / _____

and decreases with: *nothing decreases this pain / medication / postural or positional changes / heat / ice / rest*

Bladder and Bowel Function:

How many times do you usually urinate during the day? _____ During the night?_____

Voiding is often: incomplete / frequent.

I have *(stress - urge) urinary incontinence / difficulty initiating urination / incomplete emptying of bladder.*

I have **pain** up to #____/10 *before / during / after* urination.

I often have *diarrhea / constipation* / bowel incontinence / to strain during bowel movements_____.

I have **pain** up to #____/10 *before / during / after* bowel movements.

I have bowel movements every ____ *day(s) / ____ hour(s) ____ times a day / week.*

My stools are often *loose / soft / hard / well-formed / thin / other* _____.

Diet:

I have been eating a *normal / soft / low-residue / high fiber / pureed / liquid* diet over the past ____ *days / weeks / months.*

I do / not experience bloating _____ *minutes / hours* after eating. Bloating is *mild / moderate / severe every / most* days.

I do / not experience gas that is *mild / moderate / severe every / most* days.

Functional Levels: **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 after therapy:_____

_____

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: **N**ever, **O**nce, **S**ometimes, **F**requent, **A**lways)

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

Do you drink alcohol? *Y/N.* Drinks per *day*___ *week*___. Do you smoke? *Y/N.* Cigarettes per *day* ___ / *week*___.

Contraindications:

Do you have an active infection? Y/N Where?_____
Circle any condition you presently have: abnormal cysts / cancer / blood related disorder / HIV / lymphedema
Circle any condition you have ever had: abnormal cysts / cancer / blood related disorder / HIV / lymphedema
Explain:_____

_____

Surgery & Trauma: *(& approximate dates)*

Surgery **Date**	**Surgery** **Date**	**Trauma** **Date**
Laparoscopy	Surgery to the cervix	Car accidents
Appendectomy	Abortion, D & C (circle)	Hit on the head / back
Laparotomy	Episiotomy	Physical or sexual abuse
Adhesion removal (lysis)	Fibroid cyst removal	Falls onto tailbone, back, hip
Small bowel/colon surgery/resection	Surgery to open blocked tubes	Falls (from horse, bike, etc.)
Hernia repair(s) *(where?)*	C- section	Low back / hip injury
Gall bladder removal	Hysterectomy (*total / partial*)	Radiation therapy
Tummy tuck (abdominoplasty)	Bladder repair	Liposuction

Additional Surgeries & Traumas not listed:_____

_____

How many hospitalizations for adhesions / bowel problems? _____
Dates: _____
Have you had problems or complications from any surgeries or traumatic injuries? . . . . . *yes / no / unsure*
Explain:_____
Any broken bones? *Yes/ No*. What and when?_____
Diagnostic Tests: *Please list present or past diagnostic tests and the results:*

_____(date)_____
_____(date)_____
_____(date)_____

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

_____

Males Only:

I experience pain with: ***intercourse*** / ***erections*** / ***orgasms*** / ***other:***_____

I have decreased: *desire (libido) / arousal / satisfaction* **My orgasms are:** *normal / decreased / absent*

Have you ever been told you have adhesions? *Yes / No* **How did the physician diagnose adhesions?**_____

Were you treated for adhesions? *Yes / No* _____

How were you treated?_____

Females Only:

Sexual Function:

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*

Menstrual Pain:

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

Before my period my worst pain is #____ / 10, my average pain is #____ / 10 for ____ days on *L / R / both* side(s)

During my period my worst pain is #____ / 10, my average pain is #____ / 10 for ____ days *on L / R / both* side(s)

During ovulation my worst pain is #____ / 10, my average pain is #____ / 10 for ____ days *on 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?** _____

Reproductive Function:

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*

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)?_____

Pregnancy / delivery complications with dates ? _____

How many tubal pregnancies (ectopic) with dates?_____

How many abortions / (dates)?_____

How many miscarriages / (dates)?_____

Infertile Women: 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: _____ AMH: _____ 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_____

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)

Tubes: Left: *functional / scarred / blocked / removed / unsure* **Right**: *functional / scarred / blocked / removed / unsure*
Ovaries: 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*

Goals:

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

Primary Goal(s) _____

_____

Secondary Goal(s) _____

_____

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

_____

_____

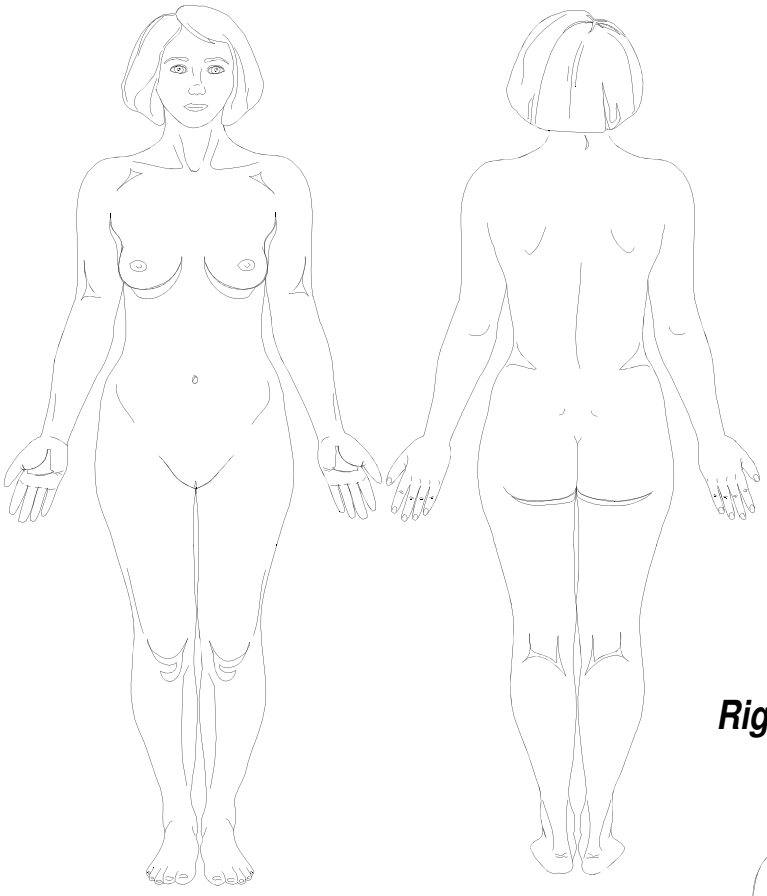
Which CPPT clinic would you prefer to attend? _____

_____

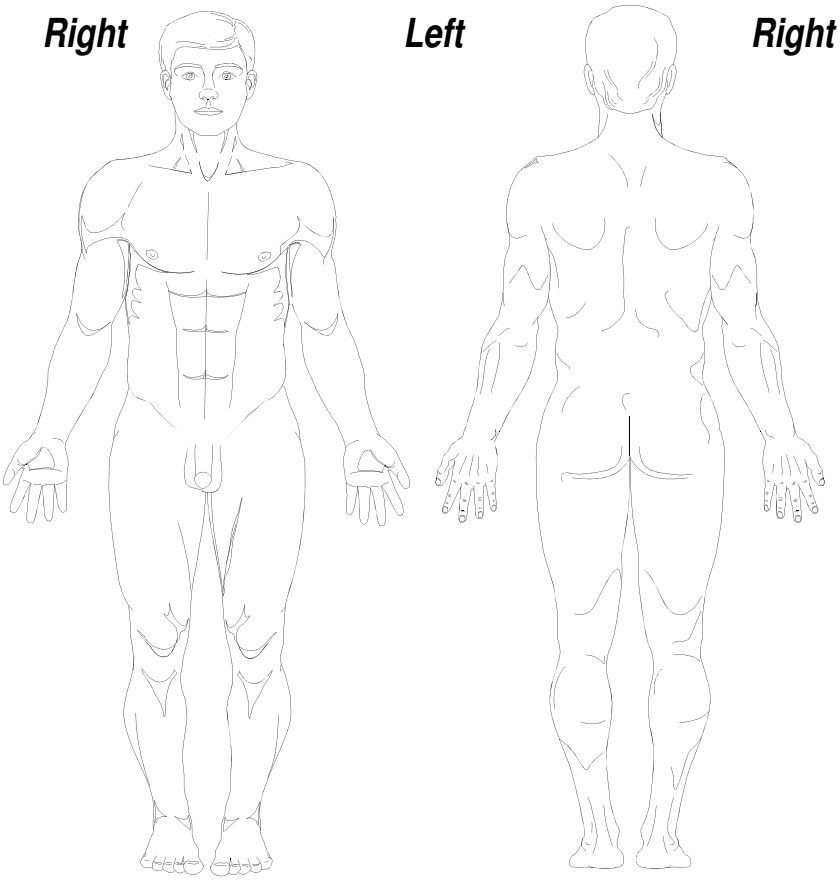
Mark your areas of pain on the figures below, as follows:

//// **Numbness** **XXXX Severe Pain** **OOOO Moderate Pain** ➛ **Shooting Pain**

Right ***Left*** ***Right***



Right ***Left*** ***Right***



Where did you learn about Clear Passage? Please circle all that apply

Web Search (Google, Bing, etc.)	eBook	Friend
Website	Podcast	Healthcare provider
Web Video (YouTube, Vimeo . .)	Conference	Newspaper
Blog, Forum, Message Board	*Overcome Infertility and Pain, Naturally* book	Magazine
Facebook	*Miracle Moms* book	TV
Twitter	Other book	Radio

Other:_____

_____

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 39th 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