physiomobility HEALTH GROUP

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SYMPTOM MONITOR

Patient Name: _____ DOB: _____ Date: _____

Presenting Problems:

_____

_____

When did this start?

_____

Occupation/Hobbies:

_____

Gynecological History – *(Please complete the following section if this applies to you)*

What age did your period start?	_____		Is your cycle regular?	☐ Yes	☐ No
How long is your cycle?	_____		Do you suffer from PMS?	☐ Yes	☐ No
Is your bleeding heavy?	☐ Yes	☐ No	Do you have pain with your period?	☐ Yes	☐ No
Do you use tampons?	☐ Yes	☐ No	If yes, when?		
Do you have pain with insertion of a tampon?	☐ Yes	☐ No	Do you have excessive discharge?	☐ Yes	☐ No
Sexually active?	☐ Yes	☐ No	Birth control?	☐ Yes	☐ No
Birth control Type: _____			Pain with intercourse?	☐ Yes	☐ No
# of pregnancies: _____			# of live births:	_____	
Wt. heaviest baby:	lbs: _____ oz: ____		Age of child(ren):	_____	
Length pushing stage:	_____ hours		# of vaginal deliveries:	_____	
# of C-sections:			Forceps?	☐ Yes	☐ No
Did you have an epidural?	☐ Yes	☐ No	Did you have a vacuum-assisted delivery?	☐ Yes	☐ No
Episiotomies?	☐ Yes	☐ No	Tears?	☐ Yes	☐ No
Grade of tear:	_____				

During my labour(s) and delivery, I felt supported and cared for:

☐ All or most of the time ☐ Some of the time ☐ A little bit ☐ Not at all

Were there times during labour and delivery that you were (or thought you were) in danger of death or injury?	☐ Yes	☐ No
Were there times when the baby was or seemed to be in danger during labour & delivery?	☐ Yes	☐ No
Do you suffer/have you suffered from post-partum depression?	☐ Yes	☐ No
Have you gone through menopause?	☐ Yes	☐ No
If so, when?	☐ Yes	☐ No
Do you suffer from vaginal dryness?	☐ Yes	☐ No
Hormone replacement therapy? ☐ Yes ☐ No	If yes, what? _____	
Do you use lubrication? ☐ Yes ☐ No	What type? _____	
Do you use vaginal moisturizer? ☐ Yes ☐ No		
Have you ever been told you have a prolapse?	☐ Yes	☐ No
If yes, what type? _____		
Do you physically feel something coming out of your vagina (with your hand)?	☐ Yes	☐ No
Do you have feelings of heaviness/pressure in your vagina?	☐ Yes	☐ No

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Prostate/Penile Health – *(Please complete the following section if this applies to you)*

Last PSA score: _____ When? _____ Last digital rectal exam? _____

Does your prostate get painful/irritated?	☐ Yes	☐ No
Has your prostate fluid been expressed and tested?	☐ Yes	☐ No
Do you have painful erections?	☐ Yes	☐ No
Can you achieve a satisfactory erection?	☐ Yes	☐ No
Do you have premature ejaculation?	☐ Yes	☐ No
Do you have pain during intercourse?	☐ Yes	☐ No

When? _____

Have you had any of the following medical procedures? If so, please provide the approximate date:

Appendectomy: _____	Bartholin Cyst: _____	Bowel resection: _____
Laparoscopy: _____	Cystoscopy: _____	Colonoscopy: _____
TVT-TVT(O): _____	Gallbladder removal: _____	Hemorrhoid surgery: _____
Mesh Procedure: _____	Hysterectomy: _____	Colostomy: _____
Vasectomy: _____	Prostatectomy: _____	Hernia repair: _____
Urodyanmics: _____	Prolapse/Vaginal repair: _____	

Other: _____

Bladder Symptoms - please complete the following section if this applies to you

Did you have problems with your bladder during childhood?	☐ Yes	☐ No	☐ Sometimes
Do you have leakage associated with sneezing, coughing, running and/or laughing?	☐ Yes	☐ No	☐ Sometimes
Other: _____			
Do you have leakage during intercourse?	☐ Yes	☐ No	☐ Sometimes
Do you feel really strong sensations prior to voiding but don't leak?	☐ Yes	☐ No	☐ Sometimes
Does your leakage occur after having a strong urge that feels uncontrollable?	☐ Yes	☐ No	☐ Sometimes
Do you have pain when your bladder fills?	☐ Yes	☐ No	☐ Sometimes
Does your pain improve when you void/urinate?	☐ Yes	☐ No	☐ Sometimes
Do you have pain when you void/urinate?	☐ Yes	☐ No	☐ Sometimes
Do you have to strain in order to empty your bladder?	☐ Yes	☐ No	☐ Sometimes
Do you have difficulty starting your urine steam?	☐ Yes	☐ No	☐ Sometimes
Do you have dribbling after you get up from the toilet?	☐ Yes	☐ No	☐ Sometimes
Do you sit on the toilet?	☐ Yes	☐ No	☐ Sometimes
Do you have incomplete emptying when you void and feel like you have to go again soon?	☐ Yes	☐ No	☐ Sometimes
Do your bladder problems cause you to leak in bed at night?	☐ Yes	☐ No	☐ Sometimes
Does your incontinence fluctuate with your cycle?	☐ Yes	☐ No	☐ Sometimes
Does your incontinence require you to wear pads?	☐ Yes	☐ No	☐ Sometimes
If you answered yes or sometimes, how often? _____ Type of pads: _____			
Do you void during the day more than the average person (5-7x/day)?	☐ Yes	☐ No	☐ Sometimes
If you answered yes or sometimes, how often? _____			
Do you need to get up at night to void?	☐ Yes	☐ No	☐ Sometimes
If you answered yes or sometimes, how many times? _____			

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Fluid intake in 24 hours

_____ cups of water/day # _____ cups of coffee/day # _____ cups of tea/day
_____ cups of other fluids/day # _____ alcoholic drinks/day/week/month

Digestion & Bowel Function

What is the frequency of your bowel movements? _____

Do you regularly feel the urge to move your bowels?	☐ Always	☐ Seldom	☐ Never
Do you have constipation?	☐ Always	☐ Seldom	☐ Never
Do you strain to have a bowel movement?	☐ Always	☐ Seldom	☐ Never
Do you splint or assist to pass stool?	☐ Always	☐ Seldom	☐ Never
Do you have loose stools/diarrhea?	☐ Always	☐ Seldom	☐ Never
Do you use your finger to help evacuate?	☐ Always	☐ Seldom	☐ Never
Do you have bowel urgency that is difficult to control?	☐ Always	☐ Seldom	☐ Never
Do you have accidental bowel leakage?	☐ Always	☐ Seldom	☐ Never
Do you have incomplete emptying?	☐ Always	☐ Seldom	☐ Never
Do you have pain with a bowel movement?	☐ Always	☐ Seldom	☐ Never
Do you have pain after a bowel movement?	☐ Always	☐ Seldom	☐ Never
Does it take longer than 5 minutes to have a bowel movement?	☐ Always	☐ Seldom	☐ Never
Do you have bloating? (Increased pressure in abdomen)	☐ Always	☐ Seldom	☐ Never
Do you experience a physical change in abdominal girth when your bowels are full (distension)?	☐ Always	☐ Seldom	☐ Never

In your opinion, is your fibre intake		☐ Too low	☐ Adequate	☐ Too high
Do you regularly use	☐ Laxatives	☐ Stool softeners	☐ Natural products	☐ Enemas

Have you ever been diagnosed with/think you have?

Irritable bowel syndrome	When? _____	Who? _____
Ulcerative colitis	When? _____	Who? _____
Crohn's Disease	When? _____	Who? _____
Celiac Disease	When? _____	Who? _____

Do you have any food allergies or sensitivities?

_____

_____

_____

Medical History

Urinary tract infections	☐ Yes	☐ No	How often? _____	
Antibiotics recently?	☐ Yes	☐ No	Last UTI? _____	
Probiotics?	☐ Yes	☐ No	Cranberry supplementation?	☐ Yes ☐ No
Smoking	☐ Yes	☐ No	# _____ packs/day	
Chronic cough	☐ Yes	☐ No		
Yeast infections	☐ Yes	☐ No	How often? _____	
Last infection: _____			Treatment: _____	
Do you get blood in your urine?	☐ Yes	☐ No	Allergies (including latex): _____	
Do you exercise?	☐ Yes	☐ No	Exercise Type: _____	
Frequency? _____				

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Low back problems	☐ Yes	☐ No	Chronic?	☐ Yes	☐ No
Mid back problems	☐ Yes	☐ No	Chronic?	☐ Yes	☐ No
Neck problems	☐ Yes	☐ No	Chronic?	☐ Yes	☐ No

Have you ever been treated for depression? ☐ Yes ☐ No

What treatment? _____

Is/was treatment effective? ☐ Yes ☐ No

Have you ever been treated for anxiety? ☐ Yes ☐ No

What treatment? _____

Is/was treatment effective? ☐ Yes ☐ No

Have you ever been diagnosed with a mental health condition? ☐ Yes ☐ No

If yes, what? _____

On a scale from 1-10, please circle and rate how much this problem bothers you

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

On a scale from 1-10, please circle and rate how motivated you are to correct this problem

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e., LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Difficulty staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Problems waking up too early	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

☐ Very Satisfied ☐ Satisfied ☐ Moderately Satisfied ☐ Dissatisfied ☐ Very Dissatisfied

How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

☐ Not at all Noticeable ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Noticeable

How WORRIED/DISTRESSED are you about your current sleep problem?

☐ Not at all Worried ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Worried

To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

☐ Not at all Interfering ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Interfering

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DASS Questionnaire

Please read each statement and circle a number, o, 1, 2, or 3, which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

S = _____ A = _____ D = _____

0 = It did not apply to me at all
1 = Applied to me to some degree or some of the time
2 = Applied to me a considerable degree, or a good part of the time
3 = Applied to me very much, or most of the time

I find it hard to wind down	S	☐ 0	☐ 1	☐ 2	☐ 3
I was aware of dryness of my mouth	A	☐ 0	☐ 1	☐ 2	☐ 3
I could not seem to experience any feeling at all	D	☐ 0	☐ 1	☐ 2	☐ 3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion	A	☐ 0	☐ 1	☐ 2	☐ 3
I found it difficult to work up the initiative to do things	D	☐ 0	☐ 1	☐ 2	☐ 3
I tended to over-react to situations	S	☐ 0	☐ 1	☐ 2	☐ 3
I experienced trembling (e.g., hands)	A	☐ 0	☐ 1	☐ 2	☐ 3
I felt that I was using a lot of nervous energy	S	☐ 0	☐ 1	☐ 2	☐ 3
I was worried about situations in which I might panic and make a fool of myself	A	☐ 0	☐ 1	☐ 2	☐ 3
I felt that I had nothing to look forward to	D	☐ 0	☐ 1	☐ 2	☐ 3
I found myself getting agitated	S	☐ 0	☐ 1	☐ 2	☐ 3
I found it difficult to relax	S	☐ 0	☐ 1	☐ 2	☐ 3
I felt down-hearted and blue	D	☐ 0	☐ 1	☐ 2	☐ 3
I was intolerant of anything that kept me from getting on with what I was doing	S	☐ 0	☐ 1	☐ 2	☐ 3
I felt I was close to panic	A	☐ 0	☐ 1	☐ 2	☐ 3
I was unable to become enthusiastic about anything	D	☐ 0	☐ 1	☐ 2	☐ 3
I felt I was not much of a person	D	☐ 0	☐ 1	☐ 2	☐ 3
I felt that I was rather touchy	S	☐ 0	☐ 1	☐ 2	☐ 3
I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	A	☐ 0	☐ 1	☐ 2	☐ 3
I felt scared without any good reason	A	☐ 0	☐ 1	☐ 2	☐ 3
I felt that life was meaningless	D	☐ 0	☐ 1	☐ 2	☐ 3

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