DEBRA GOLDMAN, PT
FOUR CORNERS PHYSICAL THERAPY
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Enclosed is the new patient history form that you are asked to complete and bring with you to your initial evaluation.

Please also bring the following:
___insurance card
___prescription (if provided by your physician)

Please note the following:

**Please arrive a minimum of 10 minutes prior to your initial evaluation to provide us with your paperwork, insurance card, etc.*

**Upon your arrival, there will be additional forms that require your review and signature.*

Four Corners Physical Therapy is **fee for service payment and payment is due at the time of your appointment.*

**This office requests 24 hours' notice to cancel an appointment or a $50.00 fee will be issued.*

**If you do not show up for a confirmed appointment, you will be charged the full fee for the session.*

Thank you.

FOUR corners
PHYSICAL THERAPY

Health History Name _____ DOB _____

1. Describe the current problem that brought you here:_____
2. When did your problem first begin? ____ months ago or ____ years ago
3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date._____
4. Since that time is it: staying the same / getting worse / getting better
Why or how? _____
5. If pain is present, rate pain on a 0-10 scale, 10 being the worst _____
Describe the nature of the pain (i.e. constant burning, intermittent ache) _____
6. Describe previous treatment/exercises _____
7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than minutes
___ Walking greater than minutes
___ Standing greater than minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list
___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers -running water/key in door
___ With nervousness/anxiety
___ No activity affects the problem

8. What relieves your symptoms? _____
9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify_____
Work, specify _____
Other _____
10. Rate the severity of this problem from 0 -10, with 0 being no problem and 10 being the worst _____
11. What are your treatment goals/concerns?_____
_____

Since the onset of your current symptoms, have you had?

Y/N Fever/Chill
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder functions
Y/N Malaise (Unexplained tiredness)
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness / Tingling
Other/Describe_____

Health History: Date of Last Physical Exam_____ Tests performed _____

General Health:

Excellent Good Average Fair Poor Occupation _____
Hours/week _____ On disability or leave? _____Activity Restrictions? _____

FOUR corners
PHYSICAL THERAPY

Pg 2 History **Name**_____

Mental Health: Current level of stress High___ Med____ Low____ Current psych therapy? Y/N
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____

Have you ever had any of the following conditions or diagnoses? CIRCLE all that apply /describe

Alcoholism/Drug problem	Diabetes	Physical or Sexual abuse
Arthritic conditions	Emphysema/chronic bronchitis	Raynaud's (cold hands and feet)
Allergies-list below	Head Injury	Rheumatoid Arthritis Hepatitis
Anemia	Hearing loss/problems	HIV/AIDS
Ankle swelling	Heart problems Epilepsy/seizures	Sacroiliac/Tailbone pain
Anorexia/bulimia	High Blood Pressure	Fibromyalgia
Asthma	Hypothyroid/ Hyperthyroid	Sexually transmitted disease
Bone Fracture	Irritable Bowel Syndrome	Smoking history
Cancer	Joint Replacement	Sports Injuries
Childhood bladder problems	Kidney disease	Stroke
Stress fracture	Latex sensitivity	TMJ/ neck pain Pelvic pain
Chronic Fatigue Syndrome	Low back pain	Vision/eye problems
Headaches	Multiple sclerosis	
Depression	Osteoporosis	

Other/Describe_____

Surgical /Procedure History

Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs
Other/describe_____

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #___
Y/N Episiotomy # ___
Y/N C-Section # ____
Y/N Difficult childbirth # _____
Y/N Prolapse or organ falling out _____
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when?____
Y/N Painful vaginal penetration
Y/N Pelvic pain
Y/N Other /describe _____

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Erectile dysfunction
Y/N Painful ejaculation
Y/N Other /describe_____

Medications - pills, injection, patch Start date Reason for taking

_____
_____
_____

Over the counter -vitamins etc Start date Reason for taking

_____
_____
_____

Pg 3 History **Name**_____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems:

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Painful urination
Y/N Trouble emptying bladder
Y/N Trouble feeling bladder urge/fullness
Y/N Difficulty stopping the urine stream
Y/N Current laxative use
Y/N Straining or pushing to empty bladder
Y/N Trouble feeling bowel/urge/fullness
Y/N Dribbling after urination
Y/N Constipation/straining
Y/N Constant urine leakage
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections
Y/N Other: Describe_____

1. Frequency of urination: Awake Hours: times/day_____ Sleep Hours: times/night ____

2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? minutes ___ hours ___ not at all ____

3. The usual amount of urine passed is:___small ____ medium ____large

4. Frequency of bowel movements: times/day ____ or times/week ____

5. When you have a bowel movement urge, how long can you delay before you have to go to the toilet? ____ minutes, ___ hours, ___ not at all

6. If constipation is present, describe management techniques: _____

7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated? _____ glasses per day.

8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___ None present
___ Times per month (specify if related to activity or your period)
___ With standing for ___ minutes or ___hours
___ With exertion or straining
___ Other

Skip remaining questions if no leakage/incontinence

9a. Bladder leakage – number of episodes**.**

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?

__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b.How much stool do you lose?

__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

11. What form of protection do you wear? (Please complete only one)

___ None
___ Minimal protection (Tissue paper/paper towel/panty shields)
___ Moderate protection (absorbent product, maxi pad)
___ Maximum protection (Specialty product/diaper)

12. On average, how many pad changes required in 24 hour period? __ # of pads