Welcome to Connect!

Please answer the following questions as well as you can, and we will go over your information during your session.

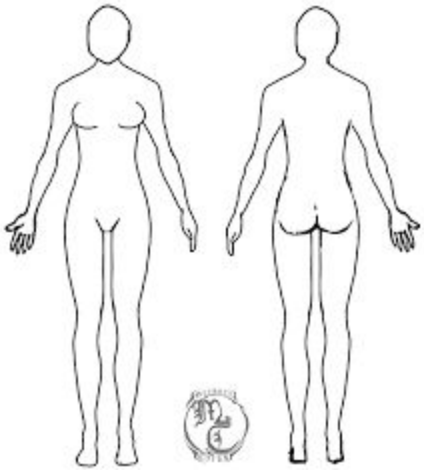
Legal Name: _____ Date of Birth: _____

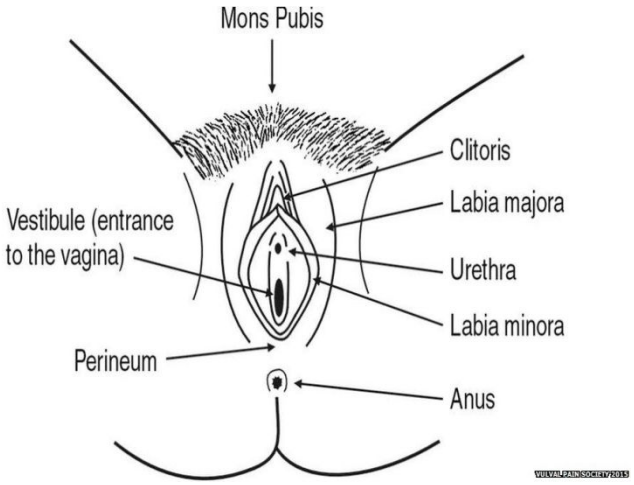
Your Gender: Chosen Name and/or Pronouns:

What symptoms are causing you to seek treatment?

What do you hope to accomplish with physical therapy?

Please mark the location of your symptoms below:





How long have you been experiencing these symptoms?

Are these symptoms limiting you in your personal or professional life?

Have you sought treatment for these symptoms? How did treatment go?

Are you having trouble with urination? If so, what difficulties are you experiencing?

Are you having periods? Are you experiencing any difficulties related to your menstrual cycle?

If you are in menopause, when did menopause begin, and are you experiencing symptoms related to menopause?

Please circle any of the following symptoms that you have experienced in the past month:

Abdominal pain
Numbness
Weakness
Numbness/Tingling
Pain at night
Nausea/vomiting
Chills
Night sweats
Headaches
Unexplained change in weight
Swelling
Dizziness
Fever

Please share what tests you have had, and write in any tests not listed:

Urine tests (dates, results):

Specialized bladder tests (dates, results):

Specialized bowel tests (dates, results):

X-rays, MRI's CT scans (dates, results):

Bloodwork (dates, results):

Other procedures: (dates, results)

Is there anything that makes your symptoms worse? Please circle any of the following below, and write in additional information not shown.

Sexual Intercourse
Tampon use
Bowel movements
Stairs
Pelvic Exam
Urination
Sitting/Standing/Walking
Bending

Are you or have you been pregnant?

Number of pregnancies:

Number of vaginal births (dates):

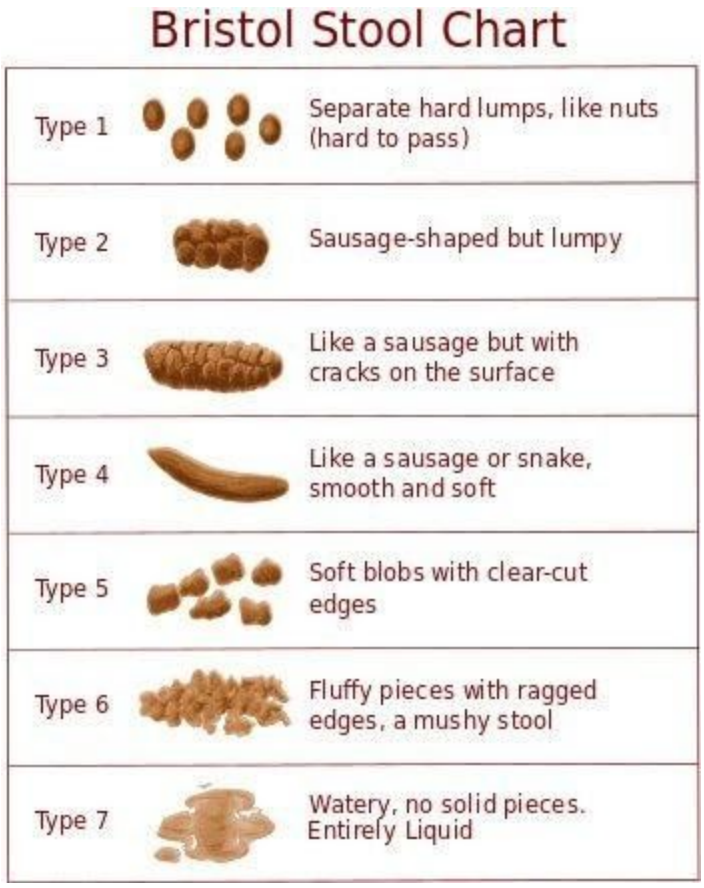
Number of caesarean births (dates):

Miscarriages, D & C's, Abortions (dates):

Please circle and provide details if you have been diagnosed with any of the following conditions:

Cancer
Stroke
High Blood pressure
Diabetes
Osteoporosis
Rheumatoid Arthritis
Osteoporosis
Heart Problems

Please describe any concerns you are having with your bowel function, and circle the stool types that you most commonly observe when you defecate:



Do you have difficulties with defecation? If so, please describe:

Please list all surgeries, medical conditions, and injuries you have experienced, even if they don't seem to relate to the problem you are having:

Please list all your current prescription and over the counter medications, vitamins and supplements you are taking, including dosages and how often. Or please provide us with a written list of your medications:

Please list allergies to products, medications, or food:

Do you smoke? If so, what product do you smoke, how often do you smoke, and how much per day?

How would you rate your general health? Poor Fair Good

Your Signature:_____ Date: _____