His therapy

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Welcome to His Therapy! Please help us serve you better by taking a few minutes to provide the following information.

NAME (last, first)			
Address			
City/State/Zip			
Phone	cell	work	home
DOB/Age			
Marital Status			
Email			
Occupation			
Emergency Contact			
Primary Care Physician			
Specialists Physician			

How did you hear about our practice?

Who can we thank for referring you to our practice?

The following is very important in our evaluation process. Please fill out these forms as specifically as possible to provide us with a clear picture of your present symptoms and functional status.

What is the primary issue/problem that brings you in today?

Secondary concerns/problem?

As a result, I am now having difficulty with:

When did your symptoms begin?

What are your personal goals for therapy?

What prior or present therapies have you have received for your current problem?

If you are currently having pain, please indicate where and how severe your pain is currently at from 0 to 10. (10 being the highest level of pain).

PLEASE check any of the following which you ***currently*** are experiencing:

___Fatigue	__Blood in your stool
___Weight loss/gain	__Leakage of urine
___Nausea/Vomiting	__Sudden urges to urinate
____Numbness or tingling	___Difficulty making it to the bathroom in time
____Diarrhea	___Pain with urination
___Constipation	____Trouble initiating a urine stream
____Leakage of stool	____Getting up more than once per night to urinate
____Pain with bowel movements	___Pain with intercourse
_____Difficulty achieving orgasm	__Lack of sexual desire
_____Feeling down or hopeless	___Anxiety
_____Straining to have a bowel movement	___Pain in the pelvis
_____Hot flashes	____Using pads due to urine or bowel leakage

Please list any **concerns or comments** that you may have at this time:

PAST MEDICAL HISTORY**:** please check the any of the following that you have ever experienced or dx with in the past

__Cancer	___Prolapse	___Osteoporosis
___Heart Problems	___Irritable Bowel Syndrome	___Diabetes
___High blood pressure	___Interstitial Cystitis	___Arthritis
___Stroke	___Bladder/Urinary tract infection	___Multiple Sclerosis
____Chemical Dependency	__Sexually Transmitted Disease	___Lung Problems
____Depression	____HIV	____Seizures
_____Sexual abuse/trauma		

List past surgeries and dates:

Pregnancy History/Including complications:

Current medication list including name, dosage and frequency: