Clear Passage Medical History Form

Clear Passage Physical Therapy maintains strict confidentiality of all information submitted to us via this form. Please print your medical history form and do one of the following:

1. Print and Fax it to us at 1.352.336.9980
2. Print, Scan and Email it to info@clearpassage.com
3. Postal mail it to 4421 NW 39th Ave. Suite 2-2, Gainesville, FL 32606, USA.

1. Contact Information

First Name: _____ Last Name: _____

Email: _____ Phone: _____ Is this a cell phone? ○ Yes ○ No

Street Address: _____ City: _____ State/Province: _____

Country: _____ Zip/Postal Code: _____

2. Physical Characteristics

Date of Birth: _____ Gender: ○ Female ○ Male

Weight (lbs) _____ Height (ft/in) _____

3. What are you seeking therapy for? (check all that apply and explain below):

- ☐ Adhesions
- ☐ Bowel Obstruction (SBO) (please note how diagnosed and if hospitalized)
- ☐ Chronic Pain
- ☐ Digestive Problems
- ☐ Endometriosis
- ☐ Failed IVF or Pre IVF
- ☐ Fallopian Tubes – Blocked
- ☐ High FSH
- ☐ Infertility
- ☐ Fallopian Tubes – Hydrosalpinx
- ☐ Post-Surgical Problems
- ☐ Sexual Problems
- ☐ SIBO (Small Intenstinal Bacterial Overgrowth)
- ☐ Other

Please explain in detail the conditions you marked above: (history, hospitalizations, how was it diagnosed, date of occurrence, etc.)

_____

4. Please answer the following if you selected infertility:

Do you have a regular menstrual cycle?
☐ Yes ☐ No

Do you ovulate?
☐ Yes ☐ No

Has your partner's sperm been tested?
☐ Yes ☐ No

If your partner's sperm has been tested, what were the results?

_____

5. Do you have any of the following conditions? (check all that apply and explain below):

☐ Abnormal Bleeding
☐ Active Infection (Viral, Bacterial, Parasitic)
☐ Autoimmune Disorders (Celiac, Crohn's, Colitis, Fibromyalgia, Graves, Lupus, RA)
☐ Bipolar/Anxiety/Depression
☐ Blood Clotting Disorder
☐ Blood Thinning Medication
☐ Cancer (Last 18 Months)
☐ Cardiac Dysfunction
☐ Connective Tissue Disorder (Explain below)
☐ DVT, Pulmonary Embolus, Stroke (Please note date below)
☐ Endometrioma
☐ Fistula
☐ Hernia (Please note size/location below.)
☐ Hepatitis
☐ Herpes
☐ HIV
☐ IUD/Essure
☐ Kidney Dysfunction
☐ Lymphedema
☐ Osteoporosis
☐ Ovarian Cysts
☐ Seizures (Please note date of last seizure below)
☐ SIBO (Small Intestinal Bacterial Overgrowth)
☐ Sickle Cell Anemia
☐ Surgery (Last 90 Days)
☐ Nothing Listed

Please explain conditions that are marked above:

_____

6. If you selected endometrioma, please answer the following questions.

Which side is the endometrioma located?

_____

What is the size of the endometrioma?

_____

7. If you selected fistula, please answer the following questions.

Where is the fistula located?

_____

What is the size of the fistula?

_____

8. If you selected ovarian cysts, please answer the following question.

Please list the size, type, and location of each cyst.

9. Do you use a wheelchair?

- ○ Yes
- ○ No

10. What are your goals for therapy?

11. Which clinic location do you prefer?

- ○ Dallas, Texas
- ○ London, England
- ○ St. Louis, Missouri
- ○ New York, New York
- ○ Reno, Nevada

12. List any and all areas of pain. If none, please write "none" in both fields:

	Area	Level of Pain (1-10, with 10 being the worst)
1		
2		
3		
4		
5		
6		

Any additional notes:

In the following section, please indicate any surgeries, radiation, trauma, or abuse:

13. Type
○ Surgery ○ Radiation ○ Trauma ○ Abuse
Est. Date of Occurrence _____
Description
_____

14. Type
○ Surgery ○ Radiation ○ Trauma ○ Abuse
Est. Date of Occurrence _____
Description
_____

15. Type
○ Surgery ○ Radiation ○ Trauma ○ Abuse
Est. Date of Occurrence _____
Description
_____

16. Type
○ Surgery ○ Radiation ○ Trauma ○ Abuse
Est. Date of Occurrence _____
Description
_____

17. Type
○ Surgery ○ Radiation ○ Trauma ○ Abuse
Est. Date of Occurrence _____
Description
_____

18. Type
○ Surgery ○ Radiation ○ Trauma ○ Abuse
Est. Date of Occurrence _____
Description
_____

19. Type
○ Surgery ○ Radiation ○ Trauma ○ Abuse
Est. Date of Occurrence _____
Description
_____

20. Type
○ Surgery ○ Radiation ○ Trauma ○ Abuse
Est. Date of Occurrence _____
Description
_____

21. Any additional areas of pain or other concerns?

	Area or Concern:
1	
2	
3	
4	
5	
6	

I assert that I am submitting a full and complete record of my medical history and present condition, to the best of my ability, and I accept that this is the legal representation of my signature.

Signature _____ Date _____