EXSTROM PHYSICAL THERAPY

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Women's Health Patient Intake

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____

Occupation: _____ **Are you currently working?** Yes / No

Does your job require lifting? Yes / No **If so, how much (lbs)?** _____

What percent of your workday do you sit? _____ **%** **Stand?** _____ **%**

Are you a tobacco smoker? Never / Former / Current **If so, how many packs/day?** _____

Are you, or could you be, pregnant? Yes / No

What is your current exercise level? (circle one)

Sedentary Lightly Active Moderately Active Very Active Extremely Active

How many days/week do you perform a regular fitness routine? _____

How well do you sleep at night? (circle one) Very Good Good Fair Poor

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PAST MEDICAL HISTORY

Have you ever had any of the following conditions or diagnoses (circle yes or no):

Cancer	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No
Stroke	Yes	No	Liver Disease	Yes	No
Asthma	Yes	No	Lung Disease (COPD)	Yes	No
Fibromyalgia	Yes	No	Osteoporosis	Yes	No
Osteoarthritis	Yes	No	Irritable Bowel Syndrome	Yes	No
Rheumatoid Arthritis	Yes	No	Hepatitis (A, B or C)	Yes	No
Pacemaker	Yes	No	HIV	Yes	No
Heart Disease	Yes	No	Sexually Transmitted Diseases	Yes	No
Latex Sensitivity	Yes	No	Physical or Sexual Abuse	Yes	No

In the past 3 months, have you experienced any of the following?

Dizziness	Yes	No	Unexplained weight loss	Yes	No
Headaches	Yes	No	Changes in bowel/bladder	Yes	No
Depression	Yes	No	Fever/chills/sweats	Yes	No
Numbness/tingling	Yes	No	Unrelenting pain at night	Yes	No
Falls/poor balance	Yes	No	Change in appetite	Yes	No

Current Medications, **OTC medication and vitamins/supplements:**

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Past Surgical History (surgery & date):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PRIMARY COMPLAINT

Describe the current problem that brought you here today. _____

_____

When did your pain/symptoms begin (approximate date)? _____

Are your symptoms currently (circle one): Getting Better / Getting Worse / About the Same

What makes your pain/symptoms better? _____

What makes your pain/symptoms worse? _____

What treatments have you received for this problem so far?

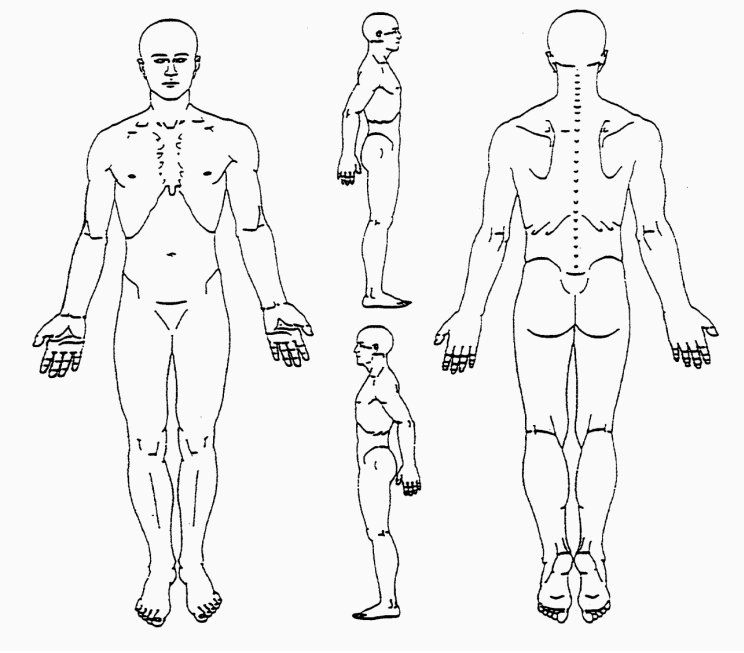
_____

Did you have surgery for this issue? Yes or No

If yes, what type of surgery? _____ **Date of surgery:** _____

Have you had similar pain/symptoms in the past? Yes / No **If so, when?** _____

BODY DIAGRAM: Please mark the areas where you feel pain on the chart below.



× Sharp pain

Dull pain or ache

••••••• Pins & needles or numbness & tingling

Shooting pain

Please mark the type and location of your pain on the body diagram.

Pain Scale: On this scale 0-10, please circle which number best represents your pain.

At worst, my pain is:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable
Currently, my pain is:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable
At best, my pain is:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

On a scale from 0%-100% provided below, circle the percent of normal function at which you are currently able to perform. This includes: work performance, activity at home, sports, socially with friends, etc.

Able to do everything 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% Unable to do anything

Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your pain or symptoms:

1. _____

2. _____

3. _____

What are your personal goals for therapy at this time? _____

_____

PELVIC HEALTH HISTORY

What was the date of your last physical exam? _____

OB/Gyn History:

Childbirth vaginal deliveries #___	Yes	No	Vaginal dryness	Yes	No
Episiotomy #_____	Yes	No	Painful periods	Yes	No
C-Section #_____	Yes	No	Menopause	Yes	No
Difficult childbirth #_____	Yes	No	Painful vaginal penetration	Yes	No
Prolapse or organ falling out	Yes	No	Pelvic pain	Yes	No
Hysterectomy	Yes	No	Endometriosis	Yes	No
IUD (Copper or hormonal)	Yes	No	Urinary incontinence	Yes	No

Other /describe_____

Bladder / Bowel Habits / Problems:

Trouble initiating urine stream	Yes	No	Blood in urine	Yes	No
Urinary intermittent /slow stream	Yes	No	Painful urination	Yes	No
Trouble emptying bladder	Yes	No	Trouble feeling bladder urge/fullness	Yes	No
Difficulty stopping the urine stream	Yes	No	Current laxative use	Yes	No
Trouble emptying bladder completely	Yes	No	Trouble feeling bowel/urge/fullness	Yes	No
Straining or pushing to empty bladder	Yes	No	Constipation/straining	Yes	No
Dribbling after urination	Yes	No	Trouble holding back gas/feces	Yes	No
Constant urine leakage	Yes	No	Recurrent bladder infections	Yes	No

Other/describe _____

What is your frequency of urination? Awake hours _____ times/day; sleep hours _____ times/night

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

What is the usual amount of urine passed? (circle one): small medium large

What is your frequency of bowel movements? _____ times/day or _____ times/week

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____ minutes, _____ hours, _____ not at all

What is your average fluid intake? _____ ounces/day **Of this, how many oz are caffeinated?** _____

How much bladder leakage/incontinence do you experience?

_____ none _____times/day _____times/week _____times/month _____only with exertion

On average, how much urine do you leak?

_____ none ___ just a few drops ___ wets underwear ___ wets outerwear ___ wets the floor

On average, how many pad/protection changes are required in 24 hours? _____# of pads

Activities/events that cause or aggravate your symptoms:

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

Other, please list _____