RESTORING your balance

Brandi Robertson, MSPT
Women's Health Physical Therapist
brandi@restoringyourbalance.com
www.restoringyourbalance.com
231.755.6410

PATIENT INTAKE FORM

Name _____ DOB _____ Date _____

Address _____ Phone _____

Email _____ Emergency Contact _____ # _____

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? Y/N
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/aggravate your symptoms. Check all that apply:

- ▫ Sitting greater than _____ minutes
- ▫ Walking greater than _____ minutes
- ▫ Standing greater than _____ minutes
- ▫ Changing position i.e. (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. Specify how your quality of life has been altered by this problem? (exclude physical activities)

Diet/Fluid intake	
Physical activity	
Work	
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?

12. Since the onset of your current symptoms have you had:

- ▫ Fever/Chills
- ▫ Malaise (Unexplained tiredness)
- ▫ Unexplained weight change
- ▫ Unexplained muscle weakness
- ▫ Dizziness or fainting
- ▫ Night pain/sweats
- ▫ Change in bowel or bladder functions
- ▫ Numbness / Tingling
- ▫ Other /describe

13. Health History: Date of Last Physical Exam _____
Tests performed:

14. General Health: ▫ Excellent ▫ Good ▫ Average ▫ Fair ▫ Poor
Occupation _____ Hours/week _____
▫ Disability or leave
▫ Activity Restrictions

15. Mental Health: Current level of stress ▫ High ▫ Med ▫ Low ▫ Current psychotherapy?

16. Activity/Exercise: None ▫ 1-2 days/week ▫ 3-4 days/week ▫ 5+ days/week
Describe...

17. Have you ever had any of the following conditions or diagnoses? Check all that apply

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

18. Ob/Gyn History

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

19. Surgical /Procedure History

- ▫ Surgery for your back/spine
- ▫ Surgery for your bladder/prostate
- ▫ Surgery for your brain
- ▫ Surgery for your bones/joints
- ▫ Surgery for your female organs
- ▫ Surgery for your abdominal organs
- ▫ Other/describe

20. Medications

Name	Pill/Injection/Patch	Start Date	Reason for Taking

21. Over the Counter – Vitamins, etc.

Name	Pill/Injection/Patch	Start Date	Reason for Taking

PELVIC SYMPTOM QUESTIONNAIRE

Bladder / Bowel Habits / Problems - Check all that apply

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

1. Urination Frequency: awake hour's times per day _____ sleep hours times per 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 volume of urine passed is: ▫ small ▫ medium ▫ large

4. Frequency of bowel movements _____ times per day _____ times per week

5. 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

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 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/pantishields)
___ Moderate protection (absorbent product, maxipad)
___ Maximum protection (specialty product/diaper)
___ Other

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