Thrive Women's Health Physical Therapy

Name:_____ Date:_____ Date of Birth:_____

Referring Physician:_____ Family MD:_____

Address: _____

Phone Number: _____ Occupation: _____

Emergency Contact (Name and Phone Number): _____

Diagnosis: _____

Do you have or have ever had ANY of the following?

	YES	NO		YES	NO
Asthma	____	____	Severe/Frequent Headaches	____	____
Shortness of Breath/Chest Pain	____	____	Vision/Hearing Difficulties	____	____
Coronary Artery Disease/Angina	____	____	Numbness or Tingling	____	____
Pacemaker	____	____	Dizziness or Fainting	____	____
High Blood Pressure	____	____	Weakness	____	____
Heart Attack	____	____	Weight Loss/Energy Loss	____	____
Night Pain	____	____	Weight Gain	____	____
Stroke/TIA	____	____	Bowel or Bladder Problems	____	____
Congestive Heart Disease	____	____	Hernia	____	____
Blood Clot/Emboli	____	____	Varicose Veins	____	____
Epilepsy/Seizure	____	____	Any Pins or Metal Implants	____	____
Thyroid Disease or Goiter	____	____	Joint Replacement Surgery	____	____
Anemia	____	____	Neck Injury/Surgery	____	____
Infectious Diseases	____	____	Shoulder Injury/Surgery	____	____
Diabetes	____	____	Elbow/Wrist/Hand Injury/Surgery	____	____
Cancer or Chemo/Radiation	____	____	Back Injury/Surgery	____	____
Arthritis	____	____	Knee Injury/Surgery	____	____
Osteoporosis	____	____	Leg/Ankle/Foot Injury/Surgery	____	____
Gout	____	____	Heart Surgery	____	____
Sleeping Problems/Difficulties	____	____	Are you Pregnant?	____	____
Emotional/Psychological Problems	____	____	Do you use Tobacco?	____	____
Depression	____	____	Sexual Dysfunction	____	____
Kidney or Liver Problems	____	____	Ulcer/Stomach Problems	____	____
Cortisone shot/Epidural	____	____	Other: _____		

Allergies (including drugs)? _____ Allergy to Latex? YES NO

Additional Information:

_____

_____

Please briefly describe the reason you currently are seeking physical therapy: _____

_____

_____

Thrive Women's Health Physical Therapy

What do you think started this problem? _____

_____

_____

FALLS RISK ASSESSMENT:

	YES	NO
Are you seeing a physician for dizziness or imbalance?	____	____
Do you have loss of balance or require assistance when getting up from sitting?	____	____
Do you have difficulty walking without holding onto furniture or walls?	____	____
Do you use an assistive device for walking (ex: cane, walker)	____	____

How many times have you fallen in the past 3 months? _____

When and how did you last fall? _____

MEDICATION LIST:

Please list ANY/ALL medications you are currently taking, include prescribed, over the counter, vitamins, etc)

Name/Dosage	Frequency	Name/Dosage	Frequency

PLEASE INFORM US IF YOU BEGIN TAKING ANY NEW MEDICATION DURING YOUR COURSE OF PHYSICAL THERAPY.

Thrive Women's Health Physical Therapy

FEMALE INTAKE FORM:

NAME: _____ DOB: _____ DATE: _____

Menstruation History (if applicable):

- Date of most recent pelvic exam: _____
- What form of birth control do you use? _____
- Date of your last period? _____
- Age when you had your first menstrual cycle? _____
- How often do you have a period? _____
- On average, how long does your period last? _____
- Do you ever experience pain with your periods? _____
  - If yes, do you need medication? _____
- What other symptoms do you experience with your period? _____

Pregnancy/Labor & Delivery History (if applicable):

- How many pregnancies have you had? _____
- How many vaginal births?: _____
- How many C-sections?: _____
- Please describe any complications with labor: _____

_____

- Did you have an episiotomy? _____ How many? _____
- Did you have any tearing? _____ What degree? _____

Infertility Issues (if applicable):

- How many tubal pregnancies (ectopics)? _____
- Have you had any miscarriages? _____ If yes, how many? _____
- Have you had any abortions? _____ If yes, how many? _____
- Have you ever been told that you are infertile? _____
- Are you undergoing any treatment for infertility? _____

Thrive Women's Health Physical Therapy

Bladder Symptoms (if applicable):

Does your problem affect your:
- Travel YES NO
- Sleep YES NO
- Social YES NO
- Job YES NO

There are 6 questions. Circle one number 0 - 4 that accurately describes your symptoms:

How often do you leak urine? 0 Never 1 1-4 times per month 2 2-4 times per week 3 Once per day 4 More than once per day	How much urine do you leak? 0 None 1 Few drops 2 Enough to soak a panty liner or underwear 3 Enough to soak a pad or wet outerwear 4 Runs down my leg or wets the floor
What type of pads/protection do you wear? 0 I do not wear any pads or panty liners 1 I wear a panty liner 2 I wear mini pads 3 I wear a maxi pad 4 I wear heavy pads like Depends/Poise or diapers	How many pads do you use? 0 I do not use any pads or panty liners 1 I only use pads during certain activities 2 I use 1 pad per day 3 I use 2-4 pads per day 4 I use more than 4 pads per day
How often do you get up at night to urinate? 0 0-1 time per night 1 1-2 times per night 2 3-4 times per night 3 5-6 times per night 4 More than 6 times per night	Activity that causes urine loss: 0 No activity causes urine loss 1 Light activity causes leakage 2 Moderate activity causes leakage 3 Vigorous activity causes leakage 4. Leak with all physical effort

Bowel History:

How often do you have a bowel movement per day? _____ Per week? _____

Are you taking anything (stool softeners, laxatives)? _____

What is your fluid intake per day? _____

What is the consistency of your stool? _____

Have you made any dietary changes? _____

Thrive Women's Health Physical Therapy

Surgical History (hysterectomy, adhesions, etc):

Type of Surgery:	Date of Surgery:
1	
2	
3	
4	

Current Sexual Activity:

	Yes	No
Pain with Intercourse		
Pain with intercourse, able to complete sex		
Pain with intercourse, disrupts/prevents sex		
Pain with intercourse prevents any attempt to have sex		
Tolerate manual/oral stimulation only - no penetration		
No pain with sex		
I am not sexually active		

Please check all activities that cause or increase your pain (if applicable):

_____ Gynecological Exam with Speculum

_____ Urination after intercourse

_____ Finger insertion into the vagina

_____ Tampon insertion

_____ Tampon removal

_____ Partner manual stimulation

_____ Friction with clothing

_____ Sports activity

_____ Urination in general

_____ Oral stimulation by partner

_____ Masturbation alone

_____ Wearing pads

_____ Other _____

Thrive Women's Health Physical Therapy

Do you have or have you ever had:

	YES	NO		YES	NO
Kidney Infection			Interstitial Cystitis		
Pelvic or Abdominal Adhesions			Kidney Stones		
Pelvic Pain			Hormonal Problems		
Cysts			Abdominal Problems		
Intestinal Problems			Digestive Problems		
Chronic Fatigue			Hemorrhoids		
Incontinence			Uterine Fibroids		
Vaginal Infection			Endometriosis		
Pelvic Inflammatory Disease			Neurological Disorder		
Vaginal Dryness			Polyps		
STD or Herpes			Other		

Is there anything else that you feel is important to tell me? _____

_____

_____