NEW PELVIC FLOOR PATIENT INTAKE FORM

PLEASE FILL OUT THE FOLLOWING FORM AS COMPLETE AS POSSIBLE; IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE OF YOU. THIS INFORMATION WILL REMAIN CONFIDENTIAL UNLESS AUTHORIZED FOR RELEASE BY THE PATIENT OR GUARDIAN.

Momentum physical therapy, p.c.

PATIENT INFORMATION:

NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____ SOCIAL SECURITY (LAST 4 DIGITS): _____ ◯ MALE ◯ FEMALE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ ◯ MARRIED ◯ SINGLE ◯ WIDOWED ◯ SEPARATED

EMAIL: _____

WOULD YOU LIKE TO RECEIVE PAPERLESS STATEMENTS (AN ADDITIONAL $4 CHARGE WILL BE ADDED TO ALL PAPER STATEMENTS):
◯ YES ◯ NO

WOULD YOU LIKE TO RECEIVE OUR MONTHLY E-NEWSLETTER: ◯ YES ◯ NO

EMERGENCY CONTACT: _____ PHONE: _____
NAME/RELATIONSHIP

REFERRING PHYSICIAN/SURGEON: _____ PRIMARY PHYSICIAN: _____

IF THE PATIENT IS A MINOR THE RESPONSIBLE PARTY MUST COMPLETE THE FOLLOWING SECTION*

RESPONSIBLE PARTY INFORMATION: RELATIONSHIP TO THE PATIENT: ◯ MOTHER ◯ FATHER ◯ GUARDIAN

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ EMAIL: _____

DATE OF BIRTH: _____ SOCIAL SECURITY (LAST 4 DIGITS): _____ ◯ MALE ◯ FEMALE

INSURANCE & BENEFIT INFORMATION: ARE YOU AWARE OF YOUR BENEFITS FOR YOUR INSURANCE? ◯ YES ◯ NO

PRIMARY INSURANCE NAME: _____

SECONDARY INSURANCE NAME: _____

IS YOUR INJURY RELATED TO EITHER OF THE FOLLOWING: ◯ N/A

◯ WORKERS COMP WORKERS COMP CARRIER: _____ CASE #:_____

◯ PERSONAL INJURY/MOTOR VEHICLE ACCIDENT CLAIM #: _____
IS AN ATTORNEY INVOLVED WITH THE CASE: ◯ YES ◯ NO
ATTORNEY NAME: _____ PHONE: _____

HAS YOUR INJURY PREVENTED YOU FROM WORKING: ◯ YES ◯ NO

CURRENT WORK STATUS:

◯CONTINUED WORK WITHOUT RESTRICTIONS ◯ WORK THE SAME JOB WITH RESTRICTIONS
◯WORK A DIFFERENT JOB WITH RESTRICTIONS ◯ UNABLE TO WORK

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PATIENT HISTORY

WHAT CONDITION ARE YOU SEEKING TREATMENT FOR:

◯ URINARY INCONTINENCE (LEAKAGE OF URINE)
◯ URGENCY – URINARY/FECAL
◯ BOWEL INCONTINENCE (LEAKAGE OF FECES)
◯ PELVIC PAIN
◯ PELVIC PROLAPSE (BULGE OR PROTRUSION IN VAGINA)
◯ PREGNANCY – PRENATAL
◯ PREGNANCY – POST PARTUM
◯ OTHER: _____

WHAT HAVE YOU DONE IN THE PAST TO IMPROVE YOUR SYMPTOMS:

_____

_____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION AT ANOTHER FACILITY: ◯ YES ◯ NO
HAVE YOU EVER DONE PHYSICAL THERAPY FOR ANOTHER CONDITION: ◯ YES ◯ NO

IS THERE ANYTHING THAT MAKES YOUR CONDITION WORSE OR BETTER:

_____

_____

ARE THERE ANY SPECIAL RELIGIOUS OR CULTURAL PRACTICES THAT MAY AFFECT OR GUIDE YOUR TREATMENT:

◯ YES: _____ ◯ NO

PLEASE LIST ANY MAJOR SURGERIES INCLUDING: HIP, BACK, PELVIC ORO ABDOMINAL AND THE YEAR OF THE SURGERY:

_____

_____

ANY RESIDUAL PAIN, COMPLICATIONS OR COMORIBIDITIES FOLLOWING SURGERY: ◯ YES ◯ NO
IF YES PLEASE LIST THEM HERE :

_____

_____

DO YOU HAVE ANY SURGICAL SCARS: ◯ YES ◯ NO
IF YES WHERE ARE THEY LOCATED:

_____

LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING BIRTH CONTROL):

_____

_____

LIST ALL OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

PLEASE LIST ALL ALLERGIES OR FOOD SENSITIVITES:

_____

HOW WOULD YOU RATE YOUR STRESS LEVEL:

◯NONE ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

HAVE YOU EVER BEEN TO COUNSELING OR PSYCHOLOGY SERVICES: ◯ YES ◯ NO

DO YOU SMOKE: ◯ YES ◯ NO IF YES: HOW MANY PACKS PER DAY: _____

DO YOU DRINK ALCOHOL: ◯ YES ◯ NO IF YES: HOW MANY DRINKS PER DAY: _____

ARE THERE ANY SUBSTANCES YOU USE REGULARLY: _____

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PATIENT HISTORY (CONT.)

FEMALE PATIENTS ONLY:

MENSTRATION (IF APPLICABLE): WHEN WAS YOUR LAST PERIOD:_____

DO YOU PAIN WITH EITHER OF THE FOLLOWING: ◯ PERIOD ◯ OVULATION

ARE YOUR CYCLES REGULAR: ◯ YES ◯ NO

PREGNANCY:

ARE YOU CURRENTLY PREGNANT: ◯ YES ◯ NO ◯ POSSIBLY

HOW MANY PREGNANCIES HAVE YOU HAD: _____

HOW MANY VAGINAL DELIVERIES: _____ OR C-SECTIONS: _____

HAVE YOU HAD ANY OF THE FOLLOWING: ◯D & C ◯ EPISOTOMY ◯ TEARING

BIRTH WEIGHT OF YOUR CHILDREN: _____

DID YOU HAVE TROUBLE HEALING: ◯ YES ◯ NO

DID YOU HAVE BOWL OR URINARY INCONTINENCE FOLLOWING PREGNANCY: ◯ YES ◯ NO

PAIN:

DO YOU HAVE PAIN WITH ANY OF THE FOLLOWING:

◯ SEXUAL INTERCOURSE ◯ SITTING ◯ PELVIC EXAM ◯ TAMPON USE

◯ TIGHT FITTING CLOTHING ◯ BIKING ◯ URINATION/BOWEL MOVEMENTS

HOW WOULD YOU RATE YOUR PAIN LEVEL:

◯NONE ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

DO YOU HAVE OR HAVE YOU HAD FREQUENT URINARY TRACT INFECTIONS: ◯ YES ◯ NO

DO YOU HAVE PAIN IN ANY OF THE FOLLOWING AREAS

◯ BACK PAIN ◯ LEG PAIN ◯ GROIN PAIN ◯ ABDOMINAL PAIN

ACTIVITY:

OCCUPATION: _____ HOBBIES: _____

WHAT DO YOU DO FOR PHYSICAL EXERCISE:

_____

_____

HOW MANY HOURS A DAY DO YOU DO THE FOLLOWING:

SIT: _____ STAND: _____ LIFT: _____ PUSH/PULL: _____

BOWEL SYMPTOMS:

DO YOU STRAIN TO HAVE A BOWEL MOVEMENT: ◯ YES ◯ NO ◯ SOMETIMES

DO YOU FEEL THAT YOUR BOWEL MOVEMENTS ARE COMPLETE: ◯ YES ◯ NO ◯ SOMETIMES

DO YOU LEAK OR STAIN FECES OR GAS: ◯ YES ◯ NO ◯ SOMETIMES

DO YOU TAKE LAXATIVES OR ENEMA WITH BOWL MOMENT: ◯ YES ◯ NO ◯ SOMETIMES

DO YOU HAVE DIARRHEA OFTEN: ◯ YES ◯ NO ◯ SOMETIMES

DO YOU INCLUDE FIBER IN YOUR DIET: ◯ YES ◯ NO ◯ SOMETIMES

DO YOU TAKE SUPPLEMENTAL FIBER: ◯ YES ◯ NO ◯ SOMETIMES

DO YOU HAVE THE STRONG URGE TO MOVE BOWELS: ◯ YES ◯ NO ◯ SOMETIMES

IF YOU LEAK STOOK HOW OFTEN DOES IT OCCUR (EVEN SMEARING): _____ PER DAY/WEEK

HOW OFTEN DO YOU MOVE YOUR BOWELS: _____ PER DAY/WEEK

WHAT IS THE MOST COMMON STOOL CONSISTENCY FOR YOU:

◯ LIQUID ◯ SOFT ◯ FIRM ◯ PELLETS ◯ OTHER: _____

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PATIENT HISTORY (CONT.)

FLUID INTAKE: HOW MANY OF THE FOLLOWING DO YOU DRINK PER DAY (ONE GLASS = 8oz):
WATER: _____ CAFFEINATED DRINKS: _____ NON CAFFEINATED DRINKS: _____

BLADDER SYMPTOMS:

DO YOU LOSE URINE WHEN YOU COUGH OR SNEEZE: ◯ YES ◯ NO ◯ SOMETIMES
DO YOU STRAIN TO EMPTY YOUR BLADDER: ◯ YES ◯ NO ◯ SOMETIMES
DO YOU LOSE URINE WHEN YOU HEAR WATER RUNNING: ◯ YES ◯ NO ◯ SOMETIMES
DO YOU HAVE A FALLING OUR FEELING: ◯ YES ◯ NO ◯ SOMETIMES
DO YOU LOSE URINE ON THE WAY TO THE BATHROOM: ◯ YES ◯ NO ◯ SOMETIMES
DO YOU HAVE BLOOD IN YOUR URINE: ◯ YES ◯ NO ◯ SOMETIMES
DO YOU WET THE BED: ◯ YES ◯ NO ◯ SOMETIMES
DO YOU HAVE PAIN WITH A FULL BLADDER: ◯ YES ◯ NO ◯ SOMETIMES
DO YOU LOSE URINE WITH SIT TO STAND OR LIFTING: ◯ YES ◯ NO ◯ SOMETIMES
DO YOU HAVE A SUDDEN, STRONG URGE TO URINATE: ◯ YES ◯ NO ◯ SOMETIMES
DO YOU FEEL YOU FULLY EMPTY YOUR BLADDER: ◯ YES ◯ NO ◯ SOMETIMES

HOW OFTEN DO YOU URINATE IN A DAY (I.E. EVERY 30 MINUTES, EVERY HOUR ETC.): _____

HOW LONG CAN YOU DELAY THE URGE TO URINATE: _____ MINUTES/HOURS

WHERE DO YOU FEEL THE URGE TO URINATE: ◯ AT URETHRA ◯ AT BLADDER ◯ NOT SURE

HOW MANY TIMES DO YOU WAKE AT NIGHT ***BECAUSE OF*** THE URGE TO URINATE: _____
DO YOU USE PADS: ◯ YES ◯ NO

WHAT KIND: _____ HOW MANY PADS IN A DAY: _____

IF YOU LEAK HOW OFTEN DOES IT OCCUR (I.E. ONCE A DAY, 1-2/WEEK ETC.): _____

SEXUALITY:

IF YOU ARE NOT SEXUALLY ACTIVE PLEASE PICK ONE OF THE FOLLOWING:
◯ NO INTEREST ◯ NO PARTNER ◯ PARTNER IS UNABLE ◯ OTHER: _____

ARE YOU INCONTINENT OF URINE WITH SEXUAL ACTIVITY: ◯ YES ◯ NO ◯ SOMETIMES

HAVE YOU EVER BEEN RAPED OR FORCED TO ENGAGE IN SEXUAL ACTIVITY AGAINST YOUR WILL: ◯ YES ◯ NO

MALE PATIENTS ONLY:

DO YOU ACHIEVE A FULL ERECTION: ◯ YES ◯ NO ◯ SOMETIMES

LEARNING STYLE PREFERENCE:

◯ NO PREFERENCE ◯ PICTURES OR VIDEOS ◯ READING ◯ DISCUSSION

SPECIAL INTERVENTIONS:

◯ N/A ◯ LARGE PRINT ◯ CAREGIVER INSTRUCTED ◯ INTERPRETER

◯ OTHER: _____