Birth Portal Services

Physical Therapy Intake Form

Name _____ **Age**_____ **Date**_____

Phone/Cell number _____ **Preferred Gender Pronouns**_____

Mailing Address _____

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? Yes / No
Please describe and specify date of onset _____
_____

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 (0 none, 10 worst) _____
Describe the nature of the pain (i.e. constant, intermittent, burning, ache) _____
_____

6. Describe previous treatment/exercises_____
_____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than _____ minutes
___ Walking greater than _____ minutes
___ Standing greater than _____ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ 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. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other_____

10. Rate the severity of this problem on 0 -10 scale (0 no problem and 10 the worst) _____

11. What are your treatment goals/concerns?_____
_____

Since the onset of your current symptoms have you had:

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

Health History:
Date of Last Physical or Pelvic Exam _____
What testing was done for your current condition? _____
_____

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
Mental Health: Current level of stress: High Med Low Current psych therapy? Y N P
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+days/week
Describe _____

Have you ever had any of the following conditions? Y = current; N = never had; P = significant issue in past.

Neck pain	Y N P	Stroke	Y N P	Hypothyroid/ Hyperthyroid	Y N P
TMJ/Headaches	Y N P	Epilepsy/seizures	Y N P	Depression	Y N P
Back pain – Low-Mid-Uppe	Y N P	Multiple Sclerosis	Y N P	Disordered eating	Y N P
Sacroiliac pain	Y N P	Head Injury	Y N P	Alcoholism/Drug problems	Y N P
Tailbone pain	Y N P	Cancer	Y N P	Smoking	Y N P
Arthritic conditions	Y N P	Heart problems	Y N P	Emotional abuse	Y N P
Rheumatoid Arthritis	Y N P	High blood pressure	Y N P	Physical abuse	Y N P
Joint replacement	Y N P	Ankle swelling	Y N P	Sexual abuse	Y N P
Sports injuries	Y N P	Anemia	Y N P	Sexually transmitted disease	Y N P
Bone or stress fracture	Y N P	Blood clots	Y N P	Childhood bladder problems	Y N P
Vision/eye problems	Y N P	Asthma	Y N P	Pelvic pain	Y N P
Hearing loss/problems	Y N P	Allergies-list below	Y N P	Anal fissure	Y N P
Diabetes	Y N P	Irritable Bowel Dis.	Y N P	Hemorrhoids	Y N P
Kidney disease	Y N P	Crohn's disease	Y N P	Bladder infections	Y N P

Because violence is so common in many women's lives and because there is help available for women being abused, we respectfully ask every client about intimate partner violence. This type of violence increases in pregnancy and in no way, do we believe it's any woman's fault. Emotional/mental abuse qualifies as abuse as well.

1. Within the past year -- or since you have been pregnant -- have you been hit, slapped, kicked or otherwise physically hurt by someone? Y N P

2. Are you in a relationship with a person who threatens or physically hurts you, emotionally tears you down or makes you feel crazy? Y N P

3. Has anyone forced you to have sexual activities that made you feel uncomfortable? Y N P

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

Pelvic Symptom Questionnaire

BLADDER:

Trouble initiating urine stream	Y N	Difficulty feeling bladder fullness/ urge	Y N
Urinary intermittent /slow stream	Y N	Need to strain, bear down or push to empty bladder	Y N
Pain with urination/emptying bladder	Y N	Constant urine leakage	Y N
Trouble emptying bladder completely	Y N	Leakage of urine (see below)	Y N
Unable to stop urine stream if tried	Y N	Recurrent bladder infections	Y N
Dribbling after urination	Y N	Blood in urine	Y N

How often do you empty your bladder during the day? _____ At night? _____
When you have an urge to urinate, how long can you delay before you have to go to the toilet? _____
Do you usually pass small, medium or large amounts of urine? _____
Difficulty holding back vaginal gas? Y N P

Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Only with physical exertion/cough

On average, how much urine do you leak?
___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets floor

What form of protection do you wear?
___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
On average, how many pad/protection changes are required in 24 hours? _____ (# of pads)

BOWEL:

Daily, pain-free bowel movement (BM)	Y N	Strain with BMs	Y N
Sense of complete emptying after BM	Y N	Spend more than ten minutes on toilet	Y N
Pain with urge to have BM	Y N	Current use of laxatives	Y N
Bleed with BM	Y N	Difficulty holding back gas	Y N

Number of bowel movements per week _____
After you have the initial urge to have a BM, how long can you delay it? _____
Do you experience bowel leakage? Y N P If yes, when? _____ How often? _____
If constipation is present describe management techniques _____
Average fluid intake (8 oz = one cup) _____ cups per day.
Ounces/day of caffeinated beverages?_____

PELVIC ORGAN PROLAPSE

Do you have a feeling of pelvic heaviness/pressure (typically worse at the end of the day), or something in your vagina or something that feels like an organ "falling out" of your vagina:
___None
___Times per month (specify if related to activity or your period)
___With standing for _____ minutes or _____hours.
___With walking greater than _____ minutes
___With exertion or straining
___Other

Please indicate if you have had or currently have the following:

Endometriosis	Y N P	Pain with menstruation	Y N P
Polycystic ovarian syndrome	Y N P	Heavy or excess menstrual flow	Y N P
Uterine or ovarian cysts	Y N P	Premenopausal symptoms	Y N P
Fibroids	Y N P	Menopause	Y N P
History of childhood urinary issues	Y N P	Difficulty with orgasm	Y N P
Vaginal dryness	Y N P	Painful vaginal penetration	Y N P
Pelvic organ prolapse	Y N P	Pelvic Pain	Y N P
# Pregnancies:		# Pregnancy Losses:	
# Vaginal childbirths:		# Abortions:	
# Cesarean births:		# VBAC / TOLAC:	
# Difficult or traumatic childbirths:		# Perineal tearing with vaginal birth?	

Are you pregnant now? Y N ?
Are you actively trying to conceive? Y N soon that's the eventual goal
Are you currently using birth control? Y/N Type: _____
Any more you'd like to share about this? _____
_____
_____

EPDS-3 (Edinburgh Postnatal Depression scale – 3 questions + 1)
If you are pregnant or have recently had a baby, we would like to know how you are feeling. Please circle the ONE answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

1. ***I have been anxious or worried for no good reason***
No, not at all Hardly ever Yes, sometimes Yes, very often

2. ***I have blamed myself unnecessarily when things went wrong***
Yes, most of the time Yes, some of the time Not very often No never

3. ***I have felt scared or panicky for no very good reason***
Yes, quite a lot Yes, sometimes No, not much No, not at all

4. The thought of harming myself has occurred to me
Yes, quite often Sometimes Hardly ever Never

Is there anything that I haven't asked that you feel it would be important to share: _____
_____
_____
_____
_____
_____
_____

Thank you very much for taking the time to fill this out. We will do our best to help you meet your goals!