DEMOGRAPHICS RECORDS

PRO-MOTION Physical Therapy

PATIENT INFORMATION

Injury/Diagnosis: _____

Referral Source: _____

First Name: _____

Middle Initial: _____

Last Name: _____

Gender: ☐ *Male* ☐ *Female*

Date of Birth: mm / dd / yyyy

SSN or ID #: _____

Marital Status: ☐ *Married* ☐ *Single* ☐ *Widowed* ☐ *Minor (under 18)*

Previous Patient? ☐ *Yes* ☐ *No*

If YES, what year: yyyy

Address: _____

City: _____

State: _____

Zip code: _____

Home Phone: ( ) _____

Cell Phone: ( ) _____

Email Address: _____ @ _____

Employer: _____

Occupation: _____

Emergency Contact: _____

Cell Phone: ( ) _____

APPOINTMENT REMINDERS:

☐ **Email** ☐ **Text Message** ☐ **Voice Call** ☐ **No Reminder**

INSURANCE INFORMATION

Insurance Provider: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Employer: _____

Motor Vehicle Accident? ☐ *Yes* ☐ *No*

Work Related Accident? ☐ *Yes* ☐ *No*

Date of Injury: _____

Claim Number: _____

Claim Manager/Adjustor: _____

Phone Number: _____

PELVIC FLOOR INTAKE FORM

PRO-MOTION
Physical Therapy

CURRENT COMPLAINT:

1. Describe your main problem:

_____

_____

_____

2. When did it begin? (date/time frame) _____

   Has it recently worsened? YES NO (circle one) When did it worsen? (date/time frame)_____

3. How often do you urinate during the day?

   - ☐ Every 4 hours
   - ☐ Every 2-3 hours
   - ☐ Every 1 hour
   - ☐ Every 30-59 minutes

4. Do you get up at night to go to the bathroom? YES NO (circle one)

   If "YES", how many times? _____

5. Do you ever hae accidental leakage of urine? YES NO (circle one)

   If "YES", what specific activities or positions cause this?

☐ coughing	☐ sneezing	☐ laughing
☐ running	☐ jumping	☐ lifting
☐ changing positions (ie. sit to stand)	☐ during sexual activity	☐ positional (ie. lying down, sitting, standing)

☐ other: _____

6. If you answered "YES" to Question #5, please estimate the amount of urine leaked:

   - ☐ Few drops
   - ☐ A small gush or spurt
   - ☐ A large leak
   - ☐ Varies or other: _____

7. Do you experience any "triggers" that may cause sudden urge to urinate? YES NO (circle one)
   (ie. running water, getting out of a car, key in door)

   Other: _____

8. How long can you delay the need to urinate?

- ☐ Indefinitely
- ☐ 1+ hours
- ☐ 30 minutes
- ☐ 15 minutes
- ☐ Less than 10 minutes
- ☐ 1-2 minutes
- ☐ Not at all

9. Do you have difficulty with participation in any of the following?

- ☐ Household chores
- ☐ Ability to do physical activities (ie. walking, running, or other exercises)
- ☐ Ability to travel by car or bus for greater distance than 30 minutes from home
- ☐ Participation in social activities
- ☐ Emotional health (ie. nervousness, depression, frustration, etc.)
- ☐ Other: _____

10. Do you have awareness of the need to urinate?

- ☐ No awareness of bladder fullness
- ☐ Leaks immediately after awareness
- ☐ Leaks 1-2 minutes after awareness
- ☐ Other: _____

11. Do you use any type of protection (ie. mentrual pads or adult incontinence products) for your leakage?

YES NO (circle one) Specify: _____ Number per day: _____

12. Do you notice any difficulty during urination?

- ☐ Difficulty initiating stream
- ☐ Weak/slow urine stream
- ☐ Dribbling after stream ends
- ☐ Pain during urination
- ☐ Blood in urine, abnormal color or odor
- ☐ Pain with full bladder
- ☐ None

13. Have you every lost bowel control? YES NO (circle one)

14. Do you have difficulty controlling gas? YES NO (circle one)

15. Do you experience any problems with bowel movements?

- ☐ Frequent constipation
- ☐ Daily bowel movement
- ☐ Bowel movement every 2-3 days
- ☐ Bowel movement every 4-5 days
- ☐ Bowel urgency
- ☐ Laxative use
- ☐ Incomplete emptying
- ☐ Pain with bowel movements
- ☐ Other: _____

16. If you are sexually active, do you have pain during or after intercourse? YES NO (circle one)

If "YES", is there pain with initial penetration? YES NO (circle one)

Is there pain with full penetration? YES NO (circle one)

Other: _____

17. Do you have any irregularities with your mentrual cycle? YES NO (circle one)

Comments: _____

18. Have you ever been pregnant? YES NO (circle one)

If currently pregnant, how many weeks along are you? _____

19. If you answered "YES" to the previous question:

How many children have you had? _____

What type of births? (vaginal, cesarean) _____

Any complications during pregnancy, labor or delivery? _____

_____

Any complications after delivery? _____

_____

20. PROLAPSE- Do you have the feeling that something is "falling out" or there is pressure in that area?

- ☐ Never
- ☐ Occasionally/ with menses
- ☐ Pressure at the end of the day
- ☐ Pressure with straining
- ☐ Pressure with standing
- ☐ Perineal pressure all day

PELVIC FLOOR INTAKE FORM

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21. Have you ever had any type of medical testing, diagnostics or surgical procedures performed? (relative to your current complaints)

_____

22. Have you ever had any prior treatment for your current complaint?

_____

22. Please list any musculoskeletal surgeries or injuries (bones, muscles, ligaments) you have had or currently are experiencing.

_____

_____

ABOUT YOUR GENERAL HEALTH:

15. Please check all medical conditions that you have or have had.

Behavioral
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attack

Neurological
- ☐ Numbness/tingling weakness
- ☐ Dizziness
- ☐ Hearing problem
- ☐ Vision problem

Other:

_____

_____

Cardiovascular
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Chest pain
- ☐ Surgery
- ☐ Pace maker

Constitutional
- ☐ Abdominal pain
- ☐ Difficulty sleeping
- ☐ Malaise
- ☐ Nausea
- ☐ Sleep disturbance
- ☐ Change in appetite
- ☐ Change in memory

Pulmonary
- ☐ Shortness of breath
- ☐ COPD
- ☐ Asthma
- ☐ Lung disease

Gastrointestinal
- ☐ Stomach disorder
- ☐ IBS
- ☐ Crohn's disease

Systemic
- ☐ Cancer
- ☐ Infection
- ☐ Stroke
- ☐ Fatigue
- ☐ Unexplained weight change
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Fever

Musculoskeletal
- ☐ Past surgery
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia

Urogenital
- ☐ STD
- ☐ Pain urinating
- ☐ Incontinence