

Name: _____ Age: _____ Today's Date: _____

Describe the problem that brings you to therapy: _____

Date problem began: _____

How did your problem or injury occur? _____

Have you had treatment for this problem? (If so, please describe) _____

Please list any healthcare professional whose care you're currently under (i.e. Medical Doctor, Osteopath, Dentist, Psychiatrist/Psychologist, Chiropractor, etc.) _____

Before this problem began, how well were you functioning? _____

Since then, has your problem: Worsened Improved Stayed same

What do you hope to achieve as a result of this treatment? _____

Do you have pain? YES NO → If yes, please indicate areas and type of pain with the following symbols
ON THE BODY CHART BELOW.

SHARP
XXXX

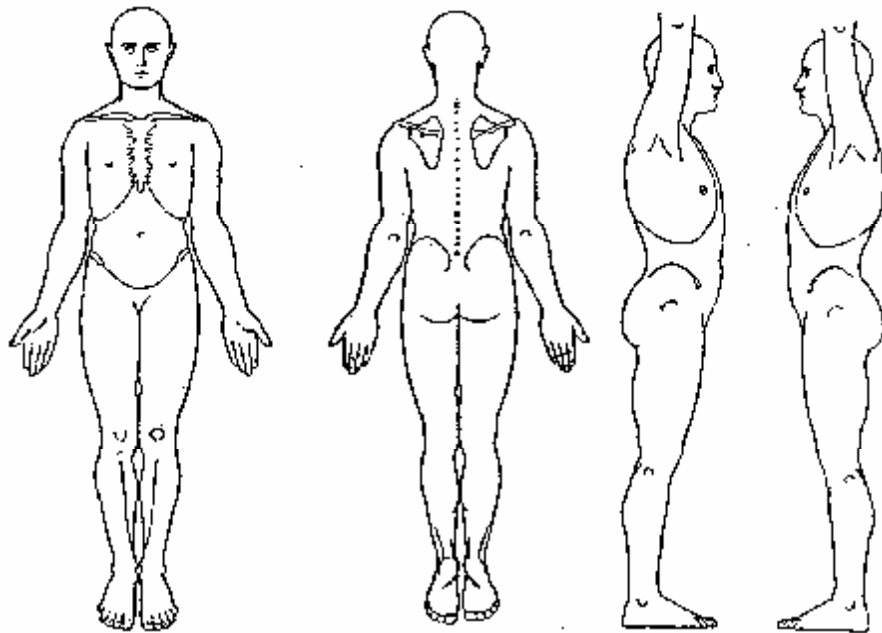
DULL
OOOOOO

ACHING
✓✓✓✓✓✓

NUMBNESS
□□□□□

TINGLING
.....
.....

BURNING
// // // // //



Is pain **constant** or does it **come and go**? (circle one)

What activities INCREASE pain/symptoms? _____

What activities DECREASE pain/symptoms? _____

Please rate your current pain on the following pain scale: (Circle the number.)

0 1 2 3 4 5 6 7 8 9 10
 (none) (Severe)

Have you had any previous orthopedic problems? If yes, specify: _____

What is your occupation? _____

What activities does your work require? (ex: lifting, prolonged sitting, standing, etc.) _____

Are you currently working? YES NO If not, when was your last day of work? _____

Living arrangement: Alone With others _____

Describe what you do to keep physically fit: _____



Olathe Medical Center
 20333 West 151st Street
 Olathe, Kansas 66061

**WOMEN'S HEALTH
 PHYSICAL THERAPY
 INTAKE QUESTIONNAIRE**

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 PATIENT LABEL
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During the past month have you been feeling down, depressed, or hopeless? YES NO
 During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
 Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please indicate (X) which of the following activities you have difficulty with or are compensating for:

___ Dressing ___ Hygiene (bathing, toileting, grooming) ___ Household activities ___ Sleeping
 ___ Walking ___ Skills with Dominant Arm ___ Work Activities ___ Sitting ___ Other _____
 ___ Sexual Intercourse – if so, is it 1) with penetration Yes No 2) with thrust Yes No
 Other _____

Past Medical History: Do you have any previous history of the following conditions?

CONDITIONS:	YES	NO	CONDITIONS:	YES	NO
High Blood Pressure			Severe Emotional Disturbance		
Heart Condition			Pacemaker		
Stroke(s)			Seizures		
Metal Implants			Cancer		
Diabetes			Shortness of Breath		
Dizziness			Persistent Night Pain		
Light Headedness			Frequent/Severe Headaches		
Excessive Fatigue			Unexplained Weight Loss		
Broken Bones (fractures)			Any history of bowel/bladder dysfunction		
Arthritis			Frequent Bladder Infections		
Fibromyalgia			Frequent Yeast Infections		
Pelvic or tailbone trauma			Hemorrhoids/Fissures		
Currently Sexually Active			IBS (Irritable Bowel Syndrome)		
Sexually Transmitted Disease			Fibroids/Cysts		
Latex Sensitivity/Allergy			Endometriosis		
Menstruation History (age of onset through what date):					
Menopause onset and symptoms:					
History of abuse (physical or emotional):					
Surgeries, Hospitalizations, or further detail on Past Medical History (list any with dates, if possible):					
List any other allergies.					
What is your learning preference? <input type="checkbox"/> Written <input type="checkbox"/> Verbal <input type="checkbox"/> Video <input type="checkbox"/> Other:					
Do you have an Advanced Directive? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, can you provide it? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, do you need more information? <input type="checkbox"/> YES <input type="checkbox"/> NO					



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If you have any bowel or bladder issues, please answer the following:

<p>How many times do you urinate during the day?</p> <input type="checkbox"/> 1-3 times <input type="checkbox"/> 10-15 times <input type="checkbox"/> 4-7 times <input type="checkbox"/> more than 15 times <input type="checkbox"/> 7-10 times	<p>Type of protection? _____ Pad changes/day</p> <input type="checkbox"/> Panty liner or minipad _____ <input type="checkbox"/> Maxi or bladder pad _____ <input type="checkbox"/> Diaper or Depends _____
<p>How many times do you urinate at night?</p> <input type="checkbox"/> None / Rarely <input type="checkbox"/> Once <input type="checkbox"/> 2-3 times <input type="checkbox"/> More than 3 times	<p>Do you have frequent bladder infections?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Is urinary sensation present?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>What causes you to lose urine?</p> <input type="checkbox"/> Cough, laugh, or sneeze <input type="checkbox"/> Other _____ <input type="checkbox"/> Physical activity / exercise _____ <input type="checkbox"/> Approaching a bathroom _____ <input type="checkbox"/> Hand washing _____ <input type="checkbox"/> Intercourse _____
<p>How long can you hold urine once you have an urge?</p> <input type="checkbox"/> As long as I need to <input type="checkbox"/> For about 30 minutes <input type="checkbox"/> For a few minutes (2-5 minutes) <input type="checkbox"/> For less than 2 minutes <input type="checkbox"/> Cannot tell when full	<p>Do you have difficulty during urination?</p> <input type="checkbox"/> Difficulty starting flow <input type="checkbox"/> Straining to finish flow <input type="checkbox"/> Strong urge / frequency <input type="checkbox"/> Slow, dribbling stream <input type="checkbox"/> Abnormal Color <input type="checkbox"/> Other: _____
<p>When you urinate, do you feel it is a</p> <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large amount?	<p>Frequency of bowel movements: _____</p> <p>Frequent Constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No Regular Laxative Use? <input type="checkbox"/> Yes <input type="checkbox"/> No Bowel sensation present? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe the shape of your stool: _____ </p>
<p>Do you feel you empty your bladder completely?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do you have any fecal leakage: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fecal leakage amount?</p> <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large Do you wear a pad for this? <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are you able to stop your flow of urine by squeezing your pelvic floor muscles? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>How many 8 oz glasses of water do you drink per day? _____</p>
<p>Do you have any urinary leakage? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please fill in the blank that best quantifies your frequency of leakage.)</p> <p>_____ times /day _____ times/night _____ times/week _____ times/month</p>	<p>Which "bladder irritants do you consume? Quantity?"</p> <input type="checkbox"/> Alcohol _____ <input type="checkbox"/> Caffeinated beverages _____ <input type="checkbox"/> Decaffeinated beverages _____ <input type="checkbox"/> Chocolate _____ <input type="checkbox"/> Citric juices _____ <input type="checkbox"/> Spicy foods _____ <input type="checkbox"/> Milk _____
<p>How much urine do you lose during an accident?</p> <input type="checkbox"/> A few drops (small amount) <input type="checkbox"/> Enough to spot clothing / pad (medium amount) <input type="checkbox"/> Most or all of bladder (large amount)	

Please let us know about any other bowel or bladder problems that you are experiencing in the space below.



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