

★★★ Are you currently receiving ANY home health services? YES NO

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

Have you had any outpatient physical therapy, occupational therapy, and/or speech-language pathology for any reason since January 1 of this year? YES NO

If yes, please describe: _____

Describe the problem that brings you to therapy: _____

Date problem began: _____

What is your goal as a result of this treatment? _____

Do you have pain? YES NO → If yes, please rate your pain on the following pain scale: (Circle the number.)
 0 (none) 1 2 3 4 5 6 7 8 9 10 (Severe)

If you do have pain, please write where your pain is located: _____

Describe what you do to keep physically fit: _____

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 _____

Do you have any previous history of the following conditions?

CONDITIONS:	YES	NO
Pelvic or tailbone trauma		
Currently Sexually Active		
Sexually Transmitted Disease		
Frequent Bladder Infections		
Frequent Yeast Infections		
Hemorrhoids / Fissures		

CONDITIONS:	YES	NO
IBS (Irritable Bowel Syndrome)		
Fibroids/Cysts		
Endometriosis		
Inflammatory Bowel Disease (e.g., Crohn's Disease)		

Obstetric History:	Date of Delivery or Miscarriage	Time Spent Pushing	Vaginal or Cesarean	Baby's Weight	Trauma or Complications

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09.0003

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

**PHYSICAL THERAPY PELVIC
 REHABILITATION INTAKE
 QUESTIONNAIRE & OUTPATIENT
 SUMMARY - WOMEN**
 Page 1 of 4
 9.25.2017; Rehab **O.M.C. No. 1240**

PLACE
 PATIENT LABEL
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Are you pregnant now or is there a chance you could be? YES NO If "Yes," how many weeks? _____

Due Date: _____ Weight Gain so far: _____

Have you recently noted (within the past 3 months):

Weight loss/gain YES NO Weakness YES NO

Nausea/Vomiting YES NO Fever/chills/sweats YES NO

Dizziness/lightheadedness YES NO Numbness or tingling YES NO

Fatigue YES NO

Languages you speak: English American Sign Language Spanish Other: _____

Preferred language for discussing healthcare: English American Sign Language Spanish Other: _____

Preferred method of communication: Verbal Sign Language Written Video Other: _____

Have you taken steroids for a prolonged period of time? YES NO

Have you had any tests in the past 6 to 12 months? (X-Ray, CT Scan, MRI, EMG, ECG, etc) _____

In the space below, please tell us anything else you think your therapist will need to know: _____

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Page 2 of 4

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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"/> 2-3 times <input type="checkbox"/> Once <input type="checkbox"/> More than 3 times	<p>Do you have frequent bladder infections?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<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>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>When you urinate, do you feel the amount is:</p> <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <p>Do you feel you empty your bladder completely?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<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>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>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 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>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>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)	<p>How many 8 oz glasses of water do you drink per day?</p> <p>_____</p>
<p>Do you have any known food allergies or sensitivities such as:</p> <input type="checkbox"/> Gluten <input type="checkbox"/> Eggs <input type="checkbox"/> Dairy <input type="checkbox"/> Artificial dyes or sweeteners <input type="checkbox"/> Soy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peanuts <input type="checkbox"/> Unknown	<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>Do you experience:</p> <input type="checkbox"/> Frequent gas <input type="checkbox"/> Bloating <input type="checkbox"/> Abdominal pain	<p>Please let us know about any other bowel or bladder problems that you are experiencing in the space below:</p>

→→→ OVER →→→

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Page 3 of 4

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Past Medical History: Do you have ANY previous history of the things listed below?

CONDITIONS:	YES	NO	CONDITIONS:	YES	NO
High Blood Pressure			Pacemaker		
Heart Condition			Seizures		
Stroke(s)			Cancer		
Metal Implants			Shortness of Breath		
Diabetes			Asthma		
Dizziness			Persistent Night Pain		
Light Headedness			Frequent/Severe Headaches		
Excessive Fatigue			Unexplained Weight Loss		
Broken Bones (fractures)			Past or Current Bowel/Bladder dysfunction		
Fibromyalgia			Gynecological Issues		
Arthritis			Vaginal/Cesarean Birth (Number: _____)		
Thyroid Problems			Did you have any back pain with your pregnancy or after childbirth?		
Kidney Problems					
Blood Clots and/or Poor Circulation			Other:		

Staff Initials	Date	Time	ALLERGIES Do you have any allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	REACTION(S)

Staff Initials	Date	Time	OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Do you have any other diagnoses &/or significant conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:

Staff Initials	Date	Time	PREVIOUS PROCEDURES / SURGERIES Do you have any previous procedures or surgeries? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:

Staff Initials	Date	Time	CURRENT MEDICATIONS <input type="checkbox"/> See attached list of medications that the patient provided. Are you currently taking any medications, including herbals? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:

INITIALS	STAFF SIGNATURE	INITIALS	STAFF SIGNATURE

TIME: _____ **DATE:** _____ **PATIENT SIGNATURE:** _____

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