

**ULTIMATE THERAPY WOMAN'S HEALTH INTAKE FORM**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_

**Referring Physician:** \_\_\_\_\_ **Family Physician** same  \_\_\_\_\_

**SOCIAL HISTORY**

**With whom do you live?**

Alone \_\_\_ Spouse/significant other \_\_\_ Spouse/significant other and children \_\_\_ Children only \_\_\_  
 Parents \_\_\_ Other relatives \_\_\_ Group setting \_\_\_ Personal care attendant \_\_\_  
 Other \_\_\_\_\_

**Employment**

Working fulltime \_\_\_\_\_  
 Working part-time \_\_\_\_\_  
 Currently not working due to condition \_\_\_\_\_  
 Homemaker \_\_\_ Student \_\_\_ Retired \_\_\_ Unemployed \_\_\_  
 Occupation: \_\_\_\_\_  
 Right handed \_\_\_ Left handed \_\_\_

**LIVING ENVIRONMENT**

**Does your home have?**

\_\_\_ Stairs, no railing  
 \_\_\_ Stairs, railing  
 \_\_\_ Ramps  
 \_\_\_ Elevator  
 \_\_\_ Uneven terrain

**Do you use?**

\_\_\_ Cane  
 \_\_\_ Walker  
 \_\_\_ Manual wheelchair  
 \_\_\_ Motorized wheelchair  
 \_\_\_ Glasses \_\_\_ hearing aides  
 Other: \_\_\_\_\_

**Where do you live?**

Private home \_\_\_ Condo \_\_\_ Apartment \_\_\_ Trailer \_\_\_ Other: \_\_\_\_\_

**GENERAL HEALTH STATUS**

Please rate your health:

Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_

**MEDICAL HISTORY (Have you had or do you currently have any of the following?)**

- |                                    |                                       |
|------------------------------------|---------------------------------------|
| ___ Asthma, Bronchitis, Emphysema  | ___ Severe or Frequent Headaches      |
| ___ Shortness of Breath/Chest Pain | ___ Vision or Hearing Difficulty      |
| ___ Coronary Artery Disease        | ___ Numbness or Tingling              |
| ___ Do you have a Pacemaker        | ___ Dizziness or Fainting             |
| ___ High Blood Pressure            | ___ Weakness                          |
| ___ Heart Attack/Heart Surgery     | ___ Weight Loss/Energy Loss           |
| ___ Blood Clot                     | ___ Hernia                            |
| ___ Stroke/TIA                     | ___ Epilepsy/Seizures                 |
| ___ Allergies                      | ___ Thyroid Issues ___ hypo ___ hyper |
| ___ Pins or Metal Implants         | ___ Incontinence                      |
| ___ Joint Replacement              | ___ Pelvic pain                       |
| ___ Diabetes                       | ___ Neck Injury/Pain                  |
| ___ Infectious Disease             | ___ Shoulder Injury/Pain              |
| ___ Cancer ___ Lymph nodes removed | ___ Elbow/Hand Injury/Pain            |
| ___ Chemo ___ Radiation            | ___ Back Injury/Pain                  |

Arthritis  
 Osteoporosis  
 Sleeping Difficulties  
 Latex Allergies  
 Bladder Infections  
 Difficult Childbirth

Knee Injury/Pain  
 Leg/Ankle/Foot Injury/Pain  
 Multiple Sclerosis  
 Parkinson's  
 Vaginal Dryness  
 Menopause (onset date \_\_\_\_\_)

Other \_\_\_\_\_

Have you ever had surgery? Yes  No  If yes, please describe, and include dates: \_\_\_\_\_

**CURRENT CONDITION(S) / CHIEF COMPLAINT(S)**

Describe the problem(s) for which you seek physical therapy: \_\_\_\_\_

What do you hope to gain from Physical Therapy? \_\_\_\_\_

Current Pain: 0 1 2 3 4 5 6 7 8 9 10

Pain at Best: 0 1 2 3 4 5 6 7 8 9 10

Pain at Worst: 0 1 2 3 4 5 6 7 8 9 10

Please describe your pain: constant  intermittent  sharp  dull  aching  stabbing  pins/needles  numbness

Does your pain awaken you at night? Yes  No  How long do you sleep before waking with pain? \_\_\_\_\_

Do you have days or periods of time when you are completely pain free? Yes  No

When did these problem(s) begin? \_\_\_\_\_

Was the onset gradual? Yes  No

If there was an injury, describe the injury: \_\_\_\_\_

How is your current condition progressing overall? Improving  Staying the same  Getting worse

What makes the problem(s) better? Heat  Ice  Rest  Medication  Other \_\_\_\_\_

What makes the problem(s) worse? Sitting  walking  standing  stairs  bending  squatting  push/pull  kneeling  reaching  lifting  rising from a chair  other \_\_\_\_\_

Are you able to continue your usual recreational activities? Yes  No Limited  – Explain: \_\_\_\_\_

**MEDICATIONS**

Do you take any Physician prescribed medications? (check all that apply)

Aspirin  Blood Thinners  
 Muscle Relaxers  Hormone replacement therapy  
 Prescribed pain relievers  Birth control pills  
 Anti-inflammatories  High blood pressure medications  
 Water pills (diuretics)  Cholesterol medication  
 Stomach/ulcer pills  Heart medications (other than for high blood pressure)  
 Antibiotics  Thyroid medication  
 Asthma medication  Insulin  
 Antidepressant medication  Seizure medication

Other: \_\_\_\_\_

Do you take any nonprescription medications (including vitamins, supplements)?

Are you allergic to any medications that you know of? \_\_\_\_\_

## Symptom Questionnaire

Bladder leakage frequency:

Never  Only with strong cough/sneeze  Only premenstrual  Constant  
 # per month/week/day (circle appropriate response)

Severity of leakage:

No leakage  Few drops  Wets underwear  Wets outerwear

Protection worn:

None  Pantishields  Minipads  Maxipad  Poise pad  Other \_\_\_\_\_

Leakage caused or increased by:

Vigorous activity or exercise  Light activity  Changing positions (sit to stand)  
 Walking to the toilet  Strong Urge to go  Intercourse or sexual activity  Other \_\_\_\_\_

Position or activity with leakage:

Lying down  Sitting  Standing

How long can you delay the need to urinate:

Not at all  1-2 min  3-10 min  11-30min  31-60min  Hours

Rate a feeling of "falling out" or pelvic heaviness/pressure:

None  Only with menstruation  With standing  With exertion  
 At the end of the day  Constant  Other \_\_\_\_\_

Fluid Intake (one glass = 8oz)

glasses per day  # of caffeinated per day  #of alcoholic per day

Rate your feelings as to the severity of this problem from 0-10 with 10 being the worst

0 \_\_\_\_\_ 10

Rate the following statement as it applies to you today

My bladder is controlling my life.  
0 \_\_\_\_\_ 10

### Bladder Habits

How often do you urinate during the day? \_\_\_\_\_ # of times

How often do you urinate after going to bed? \_\_\_\_\_ # of times

Do you take your time to go to the toilet and empty your bladder? Y/N

Number of bladder infections in the last year? \_\_\_\_\_

Can you stop the flow of urine when on the toilet? Y/N

Is the volume of urine passed usually; Large/Average/Small/Very Small

Do you have the sensation that you need to go to the toilet? Y/N

Do you strain to pass urine? Y/N

Do you empty your bladder frequently, before you experience the urge to pass urine? Y/N

Do you have the feeling your bladder is still full after urinating? Y/N

Do you have a slow or hesitant urinary stream? Y/N

Do you have difficulty initiating the urine stream? Y/N

Do you have “triggers” that make you feel like you can’t wait to go to the toilet? (running water, etc.)  
Y/N, please list \_\_\_\_\_

**Bowel Habits**

Frequency of bowel movements \_\_\_\_\_ per day \_\_\_\_\_ per week

Consistency of stool \_\_Loose \_\_Normal \_\_Hard

Do you have a history of constipation? Y/N

Do you currently strain to go? Y/N

Do you ever ignore the urge to defecate? Y/N

Do you have trouble making it to the toilet on time when you have the urge to go? Y/N

By signing below you are giving consent for treatment and acknowledging all information above is accurate and complete to the best of your knowledge.

Signature \_\_\_\_\_ date \_\_\_\_\_

**THANK YOU!**