Patient Information

Full Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____
Street Address City State Zip Code

Primary Phone: _____ Email:_____

Occupation: _____ How did you hear about Vitalize? _____

Emergency Contact Information

Full Name: _____ Relationship: _____ Phone: _____

Medical History

	Yes	No	Past
Cardiovascular			
High Blood Pressure / Pre-Eclampsia	☐	☐	☐
Heart Disease / Angina	☐	☐	☐
Heart Attack / Surgery / Pacemaker	☐	☐	☐
Stroke / TIA	☐	☐	☐
Blood Clot / Emboli / DVT	☐	☐	☐
Respiratory	☐	☐	☐
Asthma / Bronchitis / Emphysema	☐	☐	☐
Shortness of Breath / Chest Pain	☐	☐	☐
Musculoskeletal			
Arthritis	☐	☐	☐
Joint Replacement	☐	☐	☐
Osteoporosis / Osteopenia	☐	☐	☐
Gout	☐	☐	☐
Scoliosis	☐	☐	☐
TMJ / Jaw Problems	☐	☐	☐
Neurological			
Dizziness / Fainting	☐	☐	☐
Migraines / Headaches	☐	☐	☐
Seizures / Epilepsy	☐	☐	☐
Parkinson's Diseas	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Memory Loss / Cognitive Issues	☐	☐	☐
Endocrine / Metabolic			
Diabetes	☐	☐	☐
Thyroid / Goiter Problems	☐	☐	☐
Weight Loss / Gain	☐	☐	☐
PCOS	☐	☐	☐

	Yes	No	Past
Gastrointestinal / Urological			
Bowel Problems	☐	☐	☐
Bladder Problems	☐	☐	☐
Hernia			
Reproductive / Pelvic Health			
Menstrual Irregularities	☐	☐	☐
Pelvic Pain	☐	☐	☐
Menopause Symptoms	☐	☐	☐
STIs/STDs	☐	☐	☐
Mental & Emotional Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
PTSD / Trauma	☐	☐	☐
Trouble Sleeping / Insomnia	☐	☐	☐
Abuse			
Immune / Infectious			
Allergies	☐	☐	☐
Autoimmune Disease (e.g., Lupus, RA)	☐	☐	☐
Infectious Diseases	☐	☐	☐
Cancer	☐	☐	☐
Other			
Anemia	☐	☐	☐
Vision Problems	☐	☐	☐
Hearing Problems	☐	☐	☐
Metal in Body / Surgical Implants	☐	☐	☐
Fibromyalgia / Chronic Fatigue	☐	☐	☐
Ehlers-Danlos / Hypermobility	☐	☐	☐
Chiari Malformation	☐	☐	☐

Other Conditions: _____

List all surgical procedures you have had: (please list all – use back side of page if needed):

_____

Other Providers Currently Seeing _____

Medications / Supplements (please list all currently taking – use back side of page if needed)

_____

_____

CONDITIONS AND CONSENT FOR PHYSICAL THERAPY

PATIENT'S INITIALS	
	At Vitalize Physical Therapy we strive to provide you with the best, personalized care. To make this possible we ask you to adhere to the very important policies below. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.
	CONSENT FOR TREATMENT: I consent to and authorize my physical therapist to provide care and treatment prescribed by and considered necessary or advisable by the treating physical therapist and/or my physician(s). I acknowledge that no guarantees have been made to me about the results of treatment.
	ATTENDANCE/COMPLIANCE and CANCELLATION/NO SHOW POLICY: I understand that in order for physical therapy treatment to be effective, I must attend my scheduled appointments and arrive on time unless there are unusual circumstances that prevent me from attending therapy. Please call or text if you need to cancel. We have an ongoing waitlist and therefore require at least a 24 hour notice for cancellation or rescheduling of follow-up treatments and 48 hour notice for cancellation or rescheduling of initial evaluations. **No shows, cancellations or reschedules less than 24 hours in advance for follow-up treatments or 48 hours in advance for initial evaluations will be charged the full visit fee.**
	PHYSICAL THERAPY SCRIPT/REFERRAL: You may have an evaluation and treatment for PT without a script/referral. However, **PLEASE NOTE: Indiana law requires a PT script within 42 days of initiating therapy.** You can obtain a script from a physician, podiatrist, psychologist, chiropractor, dentist, physician assistant or nurse practitioner. Additionally, if you plan to seek reimbursement from your insurance, your insurance provider may require a script PRIOR to beginning PT. For more information, please ask us to supply you with an "Insurance Benefit Worksheet" so you know how to inquire about your insurance out-of-network PT benefits.
	FINANCIAL POLICY: For optimal patient care, Vitalize Physical Therapy has chosen to be an out-of-network provider. By not having a preferred provider/contracted status with insurance companies, your PT does not have to limit the time or quality of treatment provided secondary to insurance company restrictions or elevate clinic rates to pay for billing services. Upon your request, we will give you a receipt of your services that you can submit to insurance for reimbursement if you have out-of-network insurance benefits or to apply toward your annual deductible. We accept cash, check, debit or credit card payment at the time of your service (cash or check is preferred). You may also use your Health Savings or Flex Spending Account to pay for your services. The rates are as follows: $275 for Initial Evaluation + Treatment (75 minutes) --- $225 for Follow-up Treatments (50 minutes). We also offer packages for discounted rates.
	HIPAA AUTHORIZATION: We understand that health information about you is personal and we are committed to protecting it. We create a record of the care, services and assessments your receive from us. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice applies to all of the health related records of your care generated by Vitalize Physical Therapy, whether made by your personal treating practitioner or others working within Vitalize Physical Therapy. This Notice of Privacy Practices will tell you about the ways in which we may use and disclose health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to: Make sure that health information that identifies you is kept private. Give you this notice of our legal duties and privacy practices with respect to health information about you. Not retaliate against you for filing a complaint.

I have read the above information, and I consent to physical therapy evaluation and treatment. I have asked any questions and they have been answered to my satisfaction. I understand the risks, benefits and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

CONSENT AND RELEASE FOR TRIGGER POINT DRY NEEDLING

Dry needling is a technique used in physical therapy practice to treat trigger points in muscles. Trigger points are hyperirritable spots in skeletal muscle associated with hypersensitive palpable nodule in a taut band. The technique is invasive and involves placing a needle into a muscle or muscles in order to release shortened bands of muscle and decrease trigger point activity. This can help resolve pain, muscle tension and promote healing. Dry needling is performed at Vitalize Physical Therapy by a licensed physical therapist that has received additional training in this technique. My physical therapist will monitor me during dry needling and use appropriate infection control procedures to reduce the risk of infection.

Dry needling as used in physical therapy is NOT ACUPUNCTURE, NOR IS THIS ANY FORM OF ACUPUNCTURE and should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist. A complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment. Patients interested in acupuncture should consult with a state licensed acupuncturist.

This form is a consent form and general release of medical liability for this procedure. By signing this form, you are agreeing not to hold Vitalize Physical Therapy and its staff liable for any complications that may arise from the practice of this procedure. Dry needling is a valuable addition to standard therapy for musculoskeletal pain. Like any treatment, there are risks and possible complications. While complications are rare, they are real and must be considered prior to giving consent for treatment.

POTENTIAL RISKS AND COMPLICATIONS OF PROCEDURE

Complications related to dry needling are rare and do not usually require additional medical treatment. The main risks and complications associated with dry needling include: bruising, bleeding, nerve injury, infection, fainting, and increased pain. In extremely rare cases, accidental puncture of a lung may occur that could require a chest x-ray and additional medical treatment/hospitalization.

Precautions for the use of dry needling include: pregnancy, malignant tumors, bleeding disorders, medical emergencies or in replace of surgical intervention, patients on blood thinners, unstable blood pressure, and internal organ diseases.

Please indicate if you have any of these precautions: _____

CONSENT AND RELEASE OF LIABILITY

I have read this informed consent carefully. I consent to and expressly and voluntarily assume the risks of my participation in this procedure. I will inform Vitalize Physical Therapy and my Physical Therapist of any questions or concerns I have concerning my treatment. I understand that no guarantee or assurance has been made as to the results of this procedure and that may not cure my condition. I certify that I am not experiencing that contraindications listed above. I agree to indemnify, defend and hold harmless, Vitalize Physical Therapy, its officers, agents, employees, affiliates, heirs, executors, administrators, agents, successors, and assigns from and against any and all liability, suits, losses, costs, expenses, or other claim of damage whatsoever, caused by or as a result of my participation in this treatment method. I have read, understand and agree to the terms of this consent. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I acknowledge that I am signing the agreement freely and voluntarily and intend by my signature to be complete and unconditional release of all liability to the greatest extent allowed by law.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

CONSENT FORM
INTERNAL PELVIC FLOOR EVALUATION

In order to fully understand the scope of your individual diagnosis, there is important information your physical therapist needs.

Please be brief in your answers. If your physical therapist needs you to expand upon your answers, she will ask you privately.

1. Are you currently sexually active? _____ YES _____ NO

   If "No", have you been in the past? _____ YES _____ NO

2. Do you have any communicable diseases? _____ YES _____ NO

   If "Yes", please explain: _____

3. Has there been any sexual abuse in your past? _____ YES _____ NO

   If "Yes", please explain: _____

4. Have you had difficulty in the past with vaginal or rectal exams? _____ YES _____ NO

   If "Yes", please explain: _____

I give / deny (circle one) my consent for the physical therapist to do a vaginal/rectal examination for the purpose of evaluating my condition and giving therapeutic treatment.

1. I understand I can terminate the procedure at any time.
2. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the procedure.
3. I have the option of bringing a second person to be in the room with me during the procedure, and I refuse / choose (circle one) this option.
4. I have read this consent form and understand it's terms.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

PELVIC, ABDOMINAL, and SEXUAL PAIN/SYMPTOMS

*Please use back side of paper or additional paper as needed for additional explanation

WHERE IS YOUR PAIN:
☐ Low Back ☐ SI Joint ☐ Sacrum ☐ Tailbone ☐ Pubic Bone ☐ Hip ☐ Groin ☐ Bladder ☐ Perineum ☐ Anus ☐ Rectum
☐ Abdomen ☐ C-section Scar ☐ Clitoris ☐ Vulva ☐ Vagina ☐ Cervix ☐ Uterus ☐ Ovaries
☐ Testicles (Right, Left, Both) ☐ Tip of Penis ☐ Shaft of Penis ☐ Prostate ☐ Other:

RATE YOUR PAIN (0=NONE, 10=WORST PAIN IMAGINABLE)? Current: _____ /10 At best?: _____ /10 At worst?: _____ /10

DESCRIPTION: ☐ None ☐ Yes: ☐ Stabbing ☐ Aching ☐ Tender ☐ Sore ☐ Burning ☐ Prickling ☐ Sharp ☐ Shooting

WHAT INCREASES YOUR PAIN:

WHAT DECREASES YOUR PAIN:

TIME OF DAY: ☐ Unaffected MORNING: ☐ Increase ☐ Decrease AFTERNOON: ☐ Increase ☐ Decrease
EVENING: ☐ Increase ☐ Decrease NIGHTTIME: ☐ Increase ☐ Decrease

FULL BLADDER: ☐ Unaffected ☐ Increase ☐ Decrease

PAIN DURING URINATION: ☐ Unaffected ☐ Increase ☐ Decrease

AFTER URINATION: ☐ Unaffected ☐ Increase ☐ Decrease

BOWEL URGE: ☐ Unaffected ☐ Increase ☐ Decrease

DURING BOWEL MOVEMENT: ☐ Unaffected ☐ Increase ☐ Decrease

AFTER A BOWEL MOVEMENT: ☐ Unaffected ☐ Increase ☐ Decrease

CONTACT WITH CLOTHING (EXAMPLE: UNDERWEAR): ☐ Unaffected ☐ Increase ☐ Decrease

VAGINAL PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease

INITIAL PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease

DEEP PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease

AFTER PENETRATION: ☐ N/A ☐ Unaffected ☐ Increase, Duration pain lasts:

ORGASM: ☐ N/A ☐ Unaffected ☐ Increase ☐ Decrease

ARE YOU ABLE TO ACHIEVE AN ORGASM? ☐ No ☐ Yes ☐ Unsure ☐ External Stimulation ☐ Penetration

ARE YOU ABLE TO ACHIEVE AN ERECTION? ☐ N/A ☐ Yes ☐ No

ARE YOU ABLE TO MAINTAIN AN ERECTION? ☐ N/A ☐ Yes ☐ No

ARE YOU ABLE TO ACHIEVE EJACULATION? ☐ N/A ☐ Yes ☐ No

DO YOU HAVE PAIN WITH OR AFTER EJACULATION? ☐ N/A ☐ Yes ☐ No

HOW OFTEN DO YOU HAVE SEXUAL INTERCOURSE?

DO YOU HAVE A DECREASE IN SEXUAL DESIRE/DECREASED LIBIDO? ☐ No ☐ Yes. Explain:

MARINOFF SCALE – DESCRIPTIVE SCALE OF INTERCOURSE: ☐ N/A ☐ 0: No problems
☐ 1: Discomfort - does not affect completion ☐ 2: Pain interrupts/prevents completion ☐ 3: Pain prevents any attempt at intercourse

(MEN ONLY) VASECTOMY: ☐ N/A ☐ No ☐ Yes. Date:

HERNIA: ☐ N/A ☐ Inguinal ☐ Femoral ☐ Umbilical ☐ Incisional ☐ Other:
History of Hernia Repair: ☐ No ☐ Yes. Explain:

ABDOMINAL PAIN OR BLOATING: ☐ N/A ☐ No ☐ Yes. Explain:

DIGESTIVE ISSUES? ☐ No ☐ Past ☐ Present. Explain:
☐ Food Allergy or Intolerance ☐ Irritable Bowel Syndrome ☐ Inflammatory Bowel Disease ☐ Leaky Gut ☐ Colon Dysbiosis
☐ Small Intestine Bacteria Overgrowth ☐ Candida Overgrowth ☐ Ulcerative Colitis ☐ Crohn's ☐ Celiac Disease ☐ GERD
☐ Other:

PAIN FROM EATING: ☐ No ☐ Yes	PAIN FROM DRINKING: ☐ No ☐ Yes

PELVIC, ABDOMINAL, AND SEXUAL PAIN/SYMPTOMS (CONTINUED)

*Please use back side of paper or additional paper as needed for additional explanation

HISTORY OF PHYSICAL OR SEXUAL TRAUMA? ☐ No ☐ Yes. Explain:	
HISTORY OF STD's CURRENT OR PAST? ☐ No ☐ Yes. Explain: IF PAST, PLEASE LIST CURE DATE: _____/_____/_____	
CURRENT YEAST INFECTION? ☐ No ☐ Yes	HISTORY OF YEAST INFECTIONS? ☐ No ☐ Yes. How many? ____
CURRENT URINARY TRACT INFECTION (UTI)? ☐ No ☐ Yes	HISTORY OF UTI's? ☐ No ☐ Yes. How many? ____
CURRENT BACTERIAL VAGINOSIS? ☐ No ☐ Yes	HISTORY OF BACTERIAL VAGINOSIS? ☐ No ☐ Yes. How many? __
DO YOU USE LATEX CONDOMS? ☐ No ☐ Yes SENSITIVITY TO CONDOMS? ☐ No ☐ Yes	DO YOU USE LUBRICANTS? ☐ No ☐ Yes. Brand(s)? SENSITIVITY TO LUBRICANTS? ☐ No ☐ Yes

OBSTETRICS/GYNECOLOGICAL HISTORY (FEMALE ONLY)

ARE YOU CURRENTLY PREGNANT? ☐ No ☐ Yes. DUE DATE: _____/_____/_____ NUMBER OF WEEKS GESTATION: _____	
IF PREGNANT, ARE YOU HIGH RISK? ☐ No ☐ Yes	DO YOU HAVE MTHFR? ☐ No ☐ Yes
CURRENT PRENATAL SUPPLEMENTS:	
NUMBER OF PREGNANCIES: _____ NUMBER OF DELIVERIES: VAGINAL _____ C-SECTION _____ V-BACK _____	
DATES OF DELIVERIES: ____/_____/_____ , ____/_____/_____ , ____/_____/_____ , ____/_____/_____ , ____/_____/_____	
BIRTH WEIGHTS:	EPISIOTOMY OR PERINEAL TEAR? ☐ No ☐ Yes. Explain:
CURRENTLY BREASTFEEDING? ☐ No ☐ Yes	DIFFICULT CHILDBIRTH? ☐ No ☐ Yes. Explain:
POST PARTUM ANXIETY, DEPRESSION, AND/OR BABY BLUES? ☐ No ☐ Yes ☐ Unsure. Explain:	
DO YOU HAVE DIASTASIS RECTI (ABDOMINAL SEPARATION OR BELLY POOCH)? ☐ No ☐ Yes ☐ Unsure	
DIFFICULTY CONCEIVING? ☐ No ☐ Yes. Explain:	# OF MISCARRIAGES _____ # OF INFANT LOSSES _____ # OF ABORTIONS _____
MENSTRUATION: ☐ N/A CYCLE LENGTH: _____ Days DURATION OF PERIOD (BLEEDING): _____ Days	PAINFUL PERIODS? ☐ No ☐ Yes. Explain:
DIFFICULTY INSERTING OR WEARING TAMPONS? ☐ No ☐ Yes	DIFFICULTY WITH SPECULUM EXAM? ☐ No ☐ Yes
VAGINAL DRYNESS? ☐ No ☐ Yes. Explain:	CURRENTLY ON BIRTH CONTROL? ☐ No ☐ Yes. Name: TOTAL MONTHS/YEARS ON BIRTH CONTROL: _____
DO YOU HAVE ENDOMETRIOSIS? ☐ No ☐ Yes ☐ Unsure	DO YOU HAVE PCOS? ☐ No ☐ Yes ☐ Unsure
DATE OF LAST PELVIC EXAM: _____/_____/_____ RESULTS:	MENOPAUSE? ☐ No ☐ Yes. Explain:
HYSTERECTOMY: ☐ N/A ☐ No ☐ Yes. Date: ☐ Partial ☐ Total ☐ Radical ☐ Vaginal OR ☐ Laparoscopic	
ENDOMETRIAL ABLATION: ☐ N/A ☐ No ☐ Yes. Date:	
DO YOU USE BATH SALTS, VAGINAL SPRAYS, DOUCHES? ☐ No ☐ Yes. Explain:	DO YOU USE ANY OTHER VAGINAL CREAMS OR MEDICINE? ☐ No ☐ Yes. Explain:

BLADDER SYMPTOMS

*Please use back side of paper or additional paper as needed for additional explanation

WAS THERE AN EVENT ASSOCIATED WITH ONSET OF URINARY COMPLAINTS?: ☐ N/A ☐ No ☐ Yes. Please describe:		
URINE STREAM: ☐ Easy to Start ☐ Difficult to Start ☐ Strong ☐ Weak ☐ Starts & Stops ☐ Deflects to one side (Right / Left)		
EMPTYING: ☐ Complete ☐ Incomplete ☐ Pushing or straining ☐ Retention ☐ Other:	ANY DRIBBLING AFTER URINATION?: ☐ No ☐ Yes	
FREQUENCY OF URINATION: During awake hours? _____ # times per day During Sleep Hours? _____ # times per night		
DO YOU FEEL AN INTENSE URGE TO URINATE? ☐ No ☐ Yes ☐ Unsure ☐ Sometimes		
URINARY SENSATION PRESENT: ☐ No ☐ Yes ☐ Variable ☐ Sense of urgency ("I have to get to the bathroom right now!")	ONCE YOU GET THE URGE, CAN YOU HOLD BACK FROM VOIDING?: _____ minutes, _____ hours	COLOR OF URINE:
WHAT IS THE AVERAGE VOLUME OF URINATION? Specify oz OR count seconds ☐ _____ oz ☐ _____ seconds	WHAT DO YOU DRINK?	
HOW MANY CUPS OR FL OZ OF WATER DO YOU DRINK PER DAY?	CAFFEINE? ☐ None ☐ Yes, Please describe:	
CAN YOU STOP YOUR URINE ONCE STARTED?: ☐ Complete ☐ Partially ☐ Deflects ☐ Unable	DO YOU CONTRACT YOUR PELVIC FLOOR (AKA KEGEL) WHEN YOU URINATE? ☐ No ☐ Yes ☐ Sometimes	
PAIN OR BURNING WITH URINATION?: ☐ No ☐ Yes ☐ Sometimes	PAIN WITH WIPING?: ☐ No ☐ Yes ☐ Sometimes	
HOW DO YOU WIPE? ☐ Front to back ☐ Back to front ☐ Other. Explain:		
PROLAPSE, HEAVINESS, OR FEELING OF FALLING OUT IN PELVIS: ☐ No ☐ Yes ☐ Start of Menstrual Cycle (Period) ☐ Coughing/Sneezing ☐ Standing ☐ Straining ☐ At the end of the day ☐ All the time ☐ Other:		
DO YOU VOID JUST IN CASE?: ☐ No ☐ Yes ☐ Sometimes	DO YOU HOVER OVER PUBLIC TOILETS TO VOID: ☐ No ☐ Yes ☐ Sometimes	
DID YOU EXPERIENCE ANY URINARY ISSUES AS A CHILD ☐ No ☐ Yes. Please describe:		

URINARY LEAKAGE

URINARY LEAKAGE: _____ # episodes per ☐ Day ☐ Week ☐ Month	
CAUSE: ☐ None ☐ Cough ☐ Sneeze ☐ Laugh ☐ Lift ☐ Sit<>Stand ☐ Walking ☐ Jumping ☐ Running ☐ On the way to the bathroom ☐ Sound of running water ☐ Key in the door ☐ Garage door opener ☐ Other:_____	
URINE LEAKAGE AMOUNT: ☐ None ☐ Few Drops ☐ Wets Pad ☐ Wets Underwear ☐ Wets Outerwear	
DO YOU WEAR A PAD OR PROTECTIVE DEVICE?: ☐ No ☐ Yes. What kind?	# PAD(S) CHANGES REQUIRED IN 24 HOURS:
HAVE YOU EVER TAKEN MEDICINE TO PREVENT URINE LOSS: ☐ No ☐ Yes. Explain:	

BOWEL HABITS

*Please use back side of paper or additional paper as needed for additional explanation

WAS THERE AN EVENT ASSOCIATED WITH ONSET OF BOWEL COMPLAINTS?: ☐ N/A ☐ No ☐ Yes. Explain:	
BOWEL SENSATION PRESENT?: ☐ No ☐ Yes ☐ Variable	CAN YOU HOLD BACK FECES IF A BATHROOM IS NOT AVAILABLE? ☐ No ☐ Yes. How long?
FREQUENCY OF BOWEL MOVEMENTS: **#** times per day **#** times per week	
EVACUATION (POOPING) HABITS: ☐ Hold Breath ☐ Straining ☐ Splinting ☐ Other Explain:	
COLOR OF YOUR POOP:	IS YOUR STOOL: ☐ LIQUID ☐ SOFT ☐ NORMAL ☐ FIRM ☐ HARD
LAXATIVE USE: ☐ None ☐ Yes. How often per week?	ANY BLOOD ON TISSUE AFTER BOWEL MOVEMENT?: ☐ No ☐ Yes
HEMORRHOIDS: ☐ No ☐ Yes. Please describe:	
PAIN DURING BOWEL MOVEMENT: ☐ No ☐ Yes	PAIN AFTER BOWEL MOVEMENT: ☐ No ☐ Yes
FLATULENCE (GAS) LEAKAGE: ☐ None ☐ Yes. How often?	
FECAL LEAKAGE: _____ **#** episodes per ☐ Day ☐ Week ☐ **M**onth	CAUSE OF FECAL LEAKAGE: ☐ N/A ☐ Explain:
FECAL LEAKAGE AMOUNT: ☐ None ☐ Smear ☐ Diarrhea ☐ Few "Pebbles" ☐ Full Stool	
FORM OF PROTECTION: ☐ None ☐ Yes. What type of pad?:	# PAD CHANGES REQUIRED IN 24 HOURS: _____
DID YOU EXPERIENCE ANY BOWEL ISSUES AS A CHILD ☐ No ☐ Yes. Please describe:	

LIFESTYLE / QUALITY OF LIFE / FUNCTIONAL LIMITATIONS

SOCIAL ACTIVITIES: ☐ Unaffected ☐ Affected. Explain:
MARRIAGE: ☐ Unaffected ☐ Affected. Explain:
FOOD/FLUID INTAKE: ☐ Unaffected ☐ Affected. Explain: WHAT DO YOU TYPICALLY EAT AND DRINK:
DRUG, ALCOHOL, TOBACCO USE: ☐ None ☐ Yes. Explain:
PHYSICAL ACTIVITY: ☐ Unaffected ☐ Affected. Explain: CURRENT PHYSICAL ACTIVITY:
WORK: ☐ N/A ☐ Unaffected ☐ Affected. Explain: CURRENT JOB:
OTHER (SPECIFY): ☐ N/A ☐ Affected. Explain:
PATIENT GOALS:

Vitalize
physical therapy & wellness

ORTHOPEDIC QUESTIONNAIRE

What are you primary concerns with seeking physical therapy?

_____

How long have you been having symptoms/when did your symptoms begin?

_____

Was it a gradual onset or sudden?

_____

What do you think caused your injury/pain/issue?

_____

Where did the pain start? Where is it now?

_____

What makes your symptoms better? (ex: ice, heat, meds, rest, positions, movement) Please explain:

_____

What makes your symptoms worse? (ex: positions/postures, bending, reaching, lifting, deep breathing, coughing, sitting, standing, walking, household chores, recreational activities, sports, etc.) Please explain:

_____

When do you typically feel the pain? (Circle: morning, mid-day, end of day, night) Please explain:

_____

On a scale of 0-10 (0=no pain,10=worst imaginable pain), what is your pain now? ____/10; Least? ____/10; Worst? ____/10
Describe your pain (Circle: dull, aching, sore, tender, stabbing, sharp, shooting, radiating, tingling, burning, numbness), Other:

_____

Do you have any other symptoms associated with the pain such as locking, popping, weakness, etc?

_____

Have you had any abnormal symptoms: (ex: unexpected weight loss or weight gain, changes in bowel or bladder function, abnormal sensation in perianal/buttock/posterior upper thigh, vertigo or dizziness, unprovoked falls without warning) Please explain:

_____

Circle treatment received for this condition (underline if effective): chiropractic acupuncture injections PT OT massage

Have you had any imaging (x-ray, MRI, CT scan) related to this issue?

_____

Are you taking any medications for this condition? If so, when did you last take them?

_____

Have you ever had this issue in the past? Is it the same now as it was then? Did you seek help? Did it improve or resolve?

_____

Do you have a past or present history of illness?

_____

What is your job? Has this affected your ability to do your work?

_____

Tell me about your general health/lifestyle/, activity/exercise, and alcohol, drug, and/or tobacco use:

_____

History of car accident, trauma, and/or abuse (including verbal, emotional, physical, sexual)? Please Explain:

_____

Have you been experiencing any life or economic stresses? Please Explain:

_____

What is your #1 concern as we address this problem?

_____

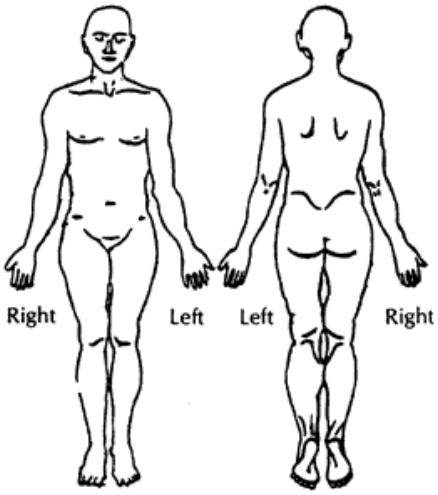
What are your top goals in coming to physical therapy?

_____

Is there anything else you would like to tell me?

_____

Please Circle or Mark ALL the areas below that are painful or uncomfortable:



Please write a time line of your condition(s) in chronological order. Details of your past can be very helpful in figuring out the root cause of your current issue, leading to quicker results for your recovery (prior pain, surgeries, falls, significant illness, traumatic events, abuse, accidents and injuries can all play a role). Please feel free to use the backside of this paper if you need more room to write.

_____

_____

_____

_____

_____

_____