



Patient Information

Full Name: _____ Date of Birth: _____

Address: _____

Street Address _____ Apartment/Unit # _____

City _____ State _____ Zip Code _____

Primary Phone: _____ Alternate Phone: _____

Email: _____ Occupation: _____

How did you hear about Vitalize PT?: _____

Emergency Contact Information

Full Name: _____ Relationship: _____ Phone: _____

Medical History

Do you now have or have you ever had any of the following conditions?

	Now	Past		Now	Past
Asthmas / Bronchitis / Emphysema	_____	_____	Cancer	_____	_____
Shortness of Breath / Chest Pain	_____	_____	Arthritis	_____	_____
Heart Disease / Angina	_____	_____	Stroke / TIA	_____	_____
Heart Attack / Surgery / Pacemaker	_____	_____	Diabetes	_____	_____
High Blood Pressure	_____	_____	Gout	_____	_____
Anemia	_____	_____	Blood Clot / Emboli	_____	_____
Allergies	_____	_____	Infectious Diseases	_____	_____
Osteoporosis	_____	_____	Vision / Hearing Problems	_____	_____
Metal in Body / Surgical Implants	_____	_____	Thyroid / Goiter Problems	_____	_____
Anxiety / Depression	_____	_____	Dizziness / Fainting	_____	_____
Weight Loss / Gain	_____	_____	Hernia	_____	_____
Bowel / Bladder Problems	_____	_____	Joint Replacement	_____	_____

List all surgical procedures you have had: _____

Other Conditions: _____

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 you 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: <ul style="list-style-type: none"> • 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
4. Have you had difficulty in the past with vaginal or rectal exams? YES NO

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:		
<input type="checkbox"/> Low Back <input type="checkbox"/> SI Joint <input type="checkbox"/> Sacrum <input type="checkbox"/> Tailbone <input type="checkbox"/> Pubic Bone <input type="checkbox"/> Hip <input type="checkbox"/> Groin <input type="checkbox"/> Bladder <input type="checkbox"/> Perineum <input type="checkbox"/> Anus <input type="checkbox"/> Rectum <input type="checkbox"/> Abdomen <input type="checkbox"/> C-section Scar <input type="checkbox"/> Clitoris <input type="checkbox"/> Vulva <input type="checkbox"/> Vagina <input type="checkbox"/> Cervix <input type="checkbox"/> Uterus <input type="checkbox"/> Ovaries <input type="checkbox"/> Testicles (Right, Left, Both) <input type="checkbox"/> Tip of Penis <input type="checkbox"/> Shaft of Penis <input type="checkbox"/> Prostate <input type="checkbox"/> Other:		
RATE YOUR PAIN (0=NONE, 10=WORST PAIN IMAGINABLE)? Current: ____/10 At best?: ____/10 At worst?: ____/10		
DESCRIPTION: <input type="checkbox"/> None <input type="checkbox"/> Yes: <input type="checkbox"/> Stabbing <input type="checkbox"/> Aching <input type="checkbox"/> Tender <input type="checkbox"/> Sore <input type="checkbox"/> Burning <input type="checkbox"/> Prickling <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting		
WHAT INCREASES YOUR PAIN:		
WHAT DECREASES YOUR PAIN:		
TIME OF DAY: <input type="checkbox"/> Unaffected	MORNING: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	AFTERNOON: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease
	EVENING: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	NIGHTTIME: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease
FULL BLADDER: <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
PAIN DURING URINATION: <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
AFTER URINATION: <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
BOWEL URGE: <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
DURING BOWEL MOVEMENT: <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
AFTER A BOWEL MOVEMENT: <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
CONTACT WITH CLOTHING (EXAMPLE: UNDERWEAR): <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
VAGINAL PENETRATION: <input type="checkbox"/> N/A <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
INITIAL PENETRATION: <input type="checkbox"/> N/A <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
DEEP PENETRATION: <input type="checkbox"/> N/A <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
AFTER PENETRATION: <input type="checkbox"/> N/A <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase, Duration pain lasts:		
ORGASM: <input type="checkbox"/> N/A <input type="checkbox"/> Unaffected <input type="checkbox"/> Increase <input type="checkbox"/> Decrease		
ARE YOU ABLE TO ACHIEVE AN ORGASM? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure <input type="checkbox"/> External Stimulation <input type="checkbox"/> Penetration		
ARE YOU ABLE TO ACHIEVE AN ERECTION? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No		
ARE YOU ABLE TO MAINTAIN AN ERECTION? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No		
ARE YOU ABLE TO ACHIEVE EJACULATION? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No		
DO YOU HAVE PAIN WITH OR AFTER EJACULATION? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No		
HOW OFTEN DO YOU HAVE SEXUAL INTERCOURSE?		
DO YOU HAVE A DECREASE IN SEXUAL DESIRE/DECREASED LIBIDO? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:		
MARINOFF SCALE – DESCRIPTIVE SCALE OF INTERCOURSE: <input type="checkbox"/> N/A <input type="checkbox"/> 0: No problems <input type="checkbox"/> 1: Discomfort - does not affect completion <input type="checkbox"/> 2: Pain interrupts/prevents completion <input type="checkbox"/> 3: Pain prevents any attempt at intercourse		
HYSTERECTOMY: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes. Date: <input type="checkbox"/> Partial <input type="checkbox"/> Total <input type="checkbox"/> Radical <input type="checkbox"/> Vaginal OR <input type="checkbox"/> Laparoscopic		
ENDOMETRIAL ABLATION: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes. Date:		
VASECTOMY: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes. Date:		
HERNIA: <input type="checkbox"/> N/A <input type="checkbox"/> Inguinal <input type="checkbox"/> Femoral <input type="checkbox"/> Umbilical <input type="checkbox"/> Incisional <input type="checkbox"/> Other:		
History of Hernia Repair: <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:		
ABDOMINAL PAIN OR BLOATING: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:		
DIGESTIVE ISSUES? <input type="checkbox"/> No <input type="checkbox"/> Past <input type="checkbox"/> Present. Explain: <input type="checkbox"/> Food Allergy or Intolerance <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Leaky Gut <input type="checkbox"/> Colon Dysbiosis <input type="checkbox"/> Small Intestine Bacteria Overgrowth <input type="checkbox"/> Candida Overgrowth <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Crohn's <input type="checkbox"/> Celiac Disease <input type="checkbox"/> GERD <input type="checkbox"/> Other:		
PAIN FROM EATING: <input type="checkbox"/> No <input type="checkbox"/> Yes		PAIN FROM DRINKING: <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:	
HISTORY OF STD's CURRENT OR PAST? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain: IF PAST, PLEASE LIST CURE DATE: ____/____/____	
CURRENT YEAST INFECTION? <input type="checkbox"/> No <input type="checkbox"/> Yes	HISTORY OF YEAST INFECTIONS? <input type="checkbox"/> No <input type="checkbox"/> Yes. How many? ____
CURRENT URINARY TRACT INFECTION (UTI)? <input type="checkbox"/> No <input type="checkbox"/> Yes	HISTORY OF UTI's? <input type="checkbox"/> No <input type="checkbox"/> Yes. How many? ____
DO YOU USE LATEX CONDOMS? <input type="checkbox"/> No <input type="checkbox"/> Yes	DO YOU USE LUBRICANTS? <input type="checkbox"/> No <input type="checkbox"/> Yes. Brand(s)?
SENSITIVITY TO CONDOMS? <input type="checkbox"/> No <input type="checkbox"/> Yes	SENSITIVITY TO LUBRICANTS? <input type="checkbox"/> No <input type="checkbox"/> Yes

OBSTETRICS/GYNECOLOGICAL HISTORY (FEMALE ONLY)

ARE YOU CURRENTLY PREGNANT? <input type="checkbox"/> No <input type="checkbox"/> Yes. DUE DATE: ____/____/____ NUMBER OF WEEKS GESTATION: ____	
IF PREGNANT, ARE YOU HIGH RISK? <input type="checkbox"/> No <input type="checkbox"/> Yes	DO YOU HAVE MTHFR? <input type="checkbox"/> No <input type="checkbox"/> Yes
CURRENT PRENATAL SUPPLEMENTS:	
NUMBER OF PREGNANCIES: ____ NUMBER OF DELIVERIES: VAGINAL ____ C-SECTION ____ V-BACK ____	
DATES OF DELIVERIES: ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____	
BIRTH WEIGHTS:	EPISIOTOMY OR PERINEAL TEAR? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:
CURRENTLY BREASTFEEDING? <input type="checkbox"/> No <input type="checkbox"/> Yes	DIFFICULT CHILDBIRTH? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:
POST PARTUM ANXIETY, DEPRESSION, AND/OR BABY BLUES? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure. Explain:	
DO YOU HAVE DIASTASIS RECTI (ABDOMINAL SEPARATION OR BELLY POOCH)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure	
DIFFICULTY CONCEIVING? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:	# OF MISCARRIAGES ____ # OF INFANT LOSSES ____ # OF ABORTIONS ____
MENSTRUATION: <input type="checkbox"/> N/A CYCLE LENGTH: ____ Days DURATION OF PERIOD (BLEEDING): ____ Days	PAINFUL PERIODS? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:
DIFFICULTY INSERTING OR WEARING TAMPONS? <input type="checkbox"/> No <input type="checkbox"/> Yes	DIFFICULTY WITH SPECULUM EXAM? <input type="checkbox"/> No <input type="checkbox"/> Yes
VAGINAL DRYNESS? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:	CURRENTLY ON BIRTH CONTROL? <input type="checkbox"/> No <input type="checkbox"/> Yes. Name: TOTAL MONTHS/YEARS ON BIRTH CONTROL: ____
DO YOU HAVE ENDOMETRIOSIS? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure	DO YOU HAVE PCOS? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure
DATE OF LAST PELVIC EXAM: ____/____/____ RESULTS:	MENOPAUSE? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:
DO YOU USE BATH SALTS, VAGINAL SPRAYS, DOUCHES? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:	DO YOU USE ANY OTHER VAGINAL CREAMS OR MEDICINE? <input type="checkbox"/> No <input type="checkbox"/> 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?: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes. Please describe:	
URINE STREAM: <input type="checkbox"/> Easy to Start <input type="checkbox"/> Difficult to Start <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Starts & Stops <input type="checkbox"/> Deflects to one side (Right / Left)	
EMPTYING: <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete <input type="checkbox"/> Pushing or straining <input type="checkbox"/> Retention <input type="checkbox"/> Other:	ANY DRIBBLING AFTER URINATION?: <input type="checkbox"/> No <input type="checkbox"/> Yes
FREQUENCY OF URINATION: During awake hours? _____ # times per day During Sleep Hours? _____ # times per night	
DO YOU FEEL AN INTENSE URGE TO URINATE? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure	
URINARY SENSATION PRESENT: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Variable <input type="checkbox"/> 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
WHAT IS THE AVERAGE VOLUME OF URINATION? Specify oz OR count seconds <input type="checkbox"/> _____ oz <input type="checkbox"/> _____ seconds	COLOR OF URINE:
WHAT DO YOU DRINK?	
HOW MANY CUPS OR FL OZ OF WATER DO YOU DRINK PER DAY?	CAFFEINE? <input type="checkbox"/> None <input type="checkbox"/> Yes, Please describe:
CAN YOU STOP YOUR URINE ONCE STARTED?: <input type="checkbox"/> Complete <input type="checkbox"/> Deflects <input type="checkbox"/> Unable	DO YOU CONTRACT YOUR PELVIC FLOOR (AKA KEGEL) WHEN YOU URINATE? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes
PAIN OR BURNING WITH URINATION?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes	PAIN WITH WIPING?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes
HOW DO YOU WIPE? <input type="checkbox"/> Front to back <input type="checkbox"/> Back to front <input type="checkbox"/> Other. Explain:	
PROLAPSE, HEAVINESS, OR FEELING OF FALLING OUT IN PELVIS: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Start of Menstrual Cycle (Period) <input type="checkbox"/> Coughing/Sneezing <input type="checkbox"/> Standing <input type="checkbox"/> Straining <input type="checkbox"/> At the end of the day <input type="checkbox"/> All the time <input type="checkbox"/> Other:	
DO YOU VOID JUST IN CASE?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes	DO YOU HOVER OVER PUBLIC TOILETS TO VOID: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes
DID YOU EXPERIENCE ANY URINARY ISSUES AS A CHILD <input type="checkbox"/> No <input type="checkbox"/> Yes. Please describe:	

URINARY LEAKAGE

URINARY LEAKAGE: _____ # episodes per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	
CAUSE: <input type="checkbox"/> None <input type="checkbox"/> Cough <input type="checkbox"/> Sneeze <input type="checkbox"/> Laugh <input type="checkbox"/> Lift <input type="checkbox"/> Sit<>Stand <input type="checkbox"/> Walking <input type="checkbox"/> Jumping <input type="checkbox"/> Running <input type="checkbox"/> On the way to the bathroom <input type="checkbox"/> Sound of running water <input type="checkbox"/> Key in the door <input type="checkbox"/> Garage door opener <input type="checkbox"/> Other: _____	
URINE LEAKAGE AMOUNT: <input type="checkbox"/> None <input type="checkbox"/> Few Drops <input type="checkbox"/> Wets Pad <input type="checkbox"/> Wets Underwear <input type="checkbox"/> Wets Outerwear	
DO YOU WEAR A PAD OR PROTECTIVE DEVICE?: <input type="checkbox"/> No <input type="checkbox"/> Yes. What kind?	# PAD(S) CHANGES REQUIRED IN 24 HOURS:
HAVE YOU EVER TAKEN MEDICINE TO PREVENT URINE LOSS: <input type="checkbox"/> No <input type="checkbox"/> 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?: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain:	
BOWEL SENSATION PRESENT?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Variable	CAN YOU HOLD BACK FECES IF A BATHROOM IS NOT AVAILABLE? <input type="checkbox"/> No <input type="checkbox"/> Yes. How long?
FREQUENCY OF BOWEL MOVEMENTS: # times per day, # times per week	
EVACUATION (POOPING) HABITS: <input type="checkbox"/> Hold Breath <input type="checkbox"/> Straining <input type="checkbox"/> Splinting <input type="checkbox"/> Other Explain:	
COLOR OF YOUR POOP:	IS YOUR STOOL: <input type="checkbox"/> LIQUID <input type="checkbox"/> SOFT <input type="checkbox"/> NORMAL <input type="checkbox"/> FIRM <input type="checkbox"/> HARD
LAXATIVE USE: <input type="checkbox"/> None <input type="checkbox"/> Yes. How often per week?	ANY BLOOD ON TISSUE AFTER BOWEL MOVEMENT?: <input type="checkbox"/> No <input type="checkbox"/> Yes
HEMORRHOIDS: <input type="checkbox"/> No <input type="checkbox"/> Yes. Please describe:	
PAIN DURING BOWEL MOVEMENT: <input type="checkbox"/> No <input type="checkbox"/> Yes	
PAIN AFTER BOWEL MOVEMENT: <input type="checkbox"/> No <input type="checkbox"/> Yes	
FLATULENCE (GAS) LEAKAGE: <input type="checkbox"/> None <input type="checkbox"/> Yes. How often?	
FECAL LEAKAGE: _____ # episodes per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	CAUSE OF FECAL LEAKAGE: <input type="checkbox"/> N/A <input type="checkbox"/> Explain:
FECAL LEAKAGE AMOUNT: <input type="checkbox"/> None <input type="checkbox"/> Smear <input type="checkbox"/> Diarrhea <input type="checkbox"/> Few "Pebbles" <input type="checkbox"/> Full Stool	
FORM OF PROTECTION: <input type="checkbox"/> None <input type="checkbox"/> Yes. What type of pad?:	# PAD CHANGES REQUIRED IN 24 HOURS: _____
DID YOU EXPERIENCE ANY BOWEL ISSUES AS A CHILD <input type="checkbox"/> No <input type="checkbox"/> Yes. Please describe:	

LIFESTYLE / QUALITY OF LIFE / FUNCTIONAL LIMITATIONS

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

ORTHOPEDIC QUESTIONNAIRE

What are your 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) 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:

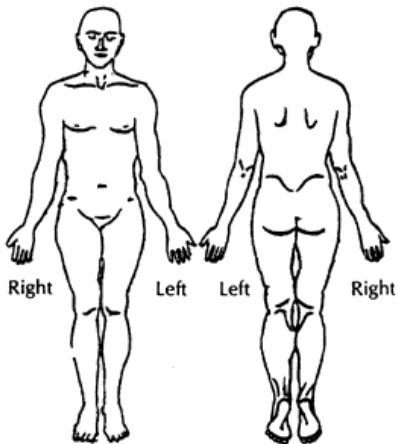
Have you been experiencing any life or economic stresses? Please Explain:

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). Feel free to use the backside of this paper if needed.
