ORTHOPEDIC & SPINE THERAPY **OBSTETRIC INTAKE FORM**

Thank you for taking the time to complete this form. Your detailed information is greatly appreciated and will help your women's health physical therapist better understand how she is able to help you.

Date of Evaluation ____/____/____ Email_____Date of next MD visit ____/____/____

Name (first/middle initial/last) _____ Age _____ D.O.B. ____/____/____

Referring Physician _____ Family Physician _____

Occupation/Job description (what do you actually do at work?) _____

Work Status: ❒ Currently working ❒ Working with restrictions ❒ Medical leave ❒ Maternity leave ❒ Other

Leisure Activities _____ Living situation (House, Apt, Other)_____

How did you choose our facility? ❒ Physician ❒ Family ❒ Friend ❒ Location ❒ Advertisement ❒ Other _____

CURRENT STATUS: (Please check the statement that applies and answer the related questions.)

____ **I am currently Pregnant.**
I am at ____weeks gestation, with the due date of _____.
Have you had any concerns during this pregnancy? No OR Yes
If yes, please specify:_____
Has your physician placed you on any restrictions? No OR Yes
If yes, please specify: _____
Have you experienced any problems during previous pregnancies? No OR Yes
If yes, please specify: _____
Are you experiencing any problems with urinating/ bowel movements or leaking urine/ feces/ gas?
Please explain:_____

____**I have had my baby already.**
I am _____ weeks post-partum, having delivered on the date of _____.
Type of delivery (circle all that apply): vaginal/ forceps/ vacuum/ episiotomy/ perineal tear/ c-section
If C-section, was it planned or did you labor prior to the procedure? Planned/ Labor
If you had a perineal tear, do you know what grade tear?_____
Did you experience any problems during this pregnancy? No OR Yes
If yes, please specify:_____
Are you experiencing problems at the site of the C-section, episiotomy or perineal tear? No OR Yes
If yes, please specify:_____
Are you experiencing any problems with urinating/ bowel movements or leaking urine/ feces/ gas?
Please explain:_____

____**I recently experienced a miscarriage.**
Date of miscarriage:_____
Any other information you feel should be shared: _____

CURRENT SYMPTOMS:
What problems or concerns would you like addressed? Explain: _____

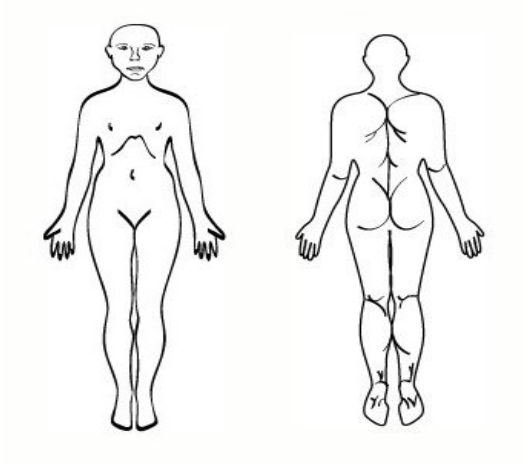
_____

When did your problem develop? (exact date) ____/____/____

How did your problem begin? _____

Since your problem began, is it: ❒ Improving ❒Staying the same ❒ Worsening

Please note on the diagram where you're experiencing pain (using the appropriate letters):



T = Tingling
D = Dull
S = Sharp
N = Numbness
B = Burning

Is your pain?

❒ Constant ❒ Intermittent

Express your pain on a scale of 0-10 (10 being extreme):

_____ At present _____ At best _____ At worst

Are there any activities or positions that significantly worsen your symptoms?

❒ Sitting ❒ Standing ❒ Walking ❒ Lifting ❒ Lying down ❒ Ice ❒ Heat ❒ Coughing/Sneezing

❒ Bending ❒ Bowel or bladder movements ❒ Other _____

Are there any activities or positions that significantly improve your symptoms?

❒ Sitting ❒ Standing ❒ Walking ❒ Lifting ❒ Lying down ❒ Ice ❒ Heat ❒ Pain medications

❒ Bending ❒ Other _____

(PLOF) What could you do before your onset of pain? (daily activities, work, leisure) _____

_____

Are you currently receiving the following treatment with another provider?

❒ Physical Therapy ❒ Chiropractic ❒ Massage ❒ Home Healthcare Services ❒ Skilled Nursing Facility Services

Have you had prior treatment(s) for this condition?

❒ Physical Therapy ❒ Chiropractic ❒ Injections ❒ Massage ❒ Surgery ❒ Acupuncture ❒ Other_____

Recent diagnostic tests? ❒ X-ray ❒ CT Scan ❒ MRI ❒ EMG ❒ Bone Scan ❒ Other _____

GYNECOLOGICAL/ CHILDBEARING HISTORY:

Number of: pregnancies_____ miscarriages_____ vaginal deliveries_____ Csections_____

Number of: episiotomies_____ Number of vacuum/ forceps assisted deliveries____

Did you experience tearing or need stitches? No OR Yes

Birthdates & weight of each baby:_____

Any problems (physical or other) after previous deliveries? _____

Any history of or currently have Feelings of: pelvic heaviess / fibroids/ cysts/ endometriosis

History of: preeclampsia/ osteoporosis/ DVTs

GENERAL HEALTH:

Please list all medications you are currently taking: _____

_____

Please check <u>all conditions</u> below that apply to you.

HEART/ CIRCULATION	BONES & JOINTS	OTHER MEDICAL CONDITIONS (cont)
○ High blood pressure	○ Chronic fatigue syndrome	○ Hearing loss
○ Pain/tightness in the chest	○ Arthritis	○ Ringing in ears
○ Cold hands/feet	○ Rheumatoid arthritis	○ Vision/eye problems
○ Numbness hands/feet	○ Fibromyalgia	○ Dizziness
○ Anemia	○ Tailbone pain	○ Depression
○ Blood clots	○ Osteoporosis	○ Anxiety
○ Easy bleeding	○ Stress fracture	○ Headaches
○ Heart attack	○ Joint replacement	○ Hyperthyroid
○ Pacemaker	○ Other _____	○ Anorexia/Bulimia
○ Bypass surgery		○ Head injury
○ Heart murmur	SURGICAL HISTORY	○ Epilepsy/seizures
○ Other_____	○ Back or neck	○ Multiple sclerosis
	○ Tubal ligation	○ Irritable bowel syndrome
LUNGS/BREATHING	○ Laparoscopy	○ Ulcers
○ Shortness of breath	○ Abdominal surgeries	○ Hernia
○ Current smoking	○ Gall bladder	○ Kidney problems
○ History of smoking	○ Bladder surgery	○ Hepatitis
○ Asthma	Pelvic surgery	○ Alcohol/drug addiction
○ Emphysema/bronchitis		○ Vomiting
	OTHER MEDICAL CONDITIONS	○ Unexplained weight change
SKIN CONDITIONS	○ Diabetes	○ Sweating
○ Eczema	○ Cancer	○ Chills
○ Contact dermatitis	○ Melanoma	○ Sexually transmitted disease
○ Psoriasis	○ Lupus	○ Falls in last 6 months
○ Lichens Simplex	○ HIV/ AIDS	○ Metal implants
○ Other_____	○ Stroke	○ Allergies

Please explain any checked items above and add others not listed: _____

_____

Past surgical history:_____

What do you hope to accomplish in physical therapy? _____

Fill out this section ONLY of you have given birth in the last 12 weeks.
Answer the following 3 questions by placing a check mark next to your response:
IN THE LAST 7 DAYS:

I have blamed myself unnecessarily when things went wrong.	I have felt panicky or scared for no very good reason.	I have been anxious or worried for no good reason.
_____Yes, all the time	_____Yes, all the time	_____Yes, all the time
_____Yes, most of the time	_____Yes, most of the time	_____Yes, most of the time
_____No, not very often	_____No, not very often	_____No, not very often
_____No, not at all	_____No, not at all	_____No, not at all

Patient Signature: _____ Date: _____

Physical Therapist Signature: _____ Date: _____