PATIENT INTAKE QUESTIONNAIRE: PRENATAL and POSTPARTUM

Name:_____ **Age:** _____ **DOB:** _____

Phone #: Home_____ Day_____ Cell_____ Work_____

Email address:_____

Please circle where we may contact you or leave messages:

Home phone Day phone Cell phone Work phone Email

Referring Doctor: _____ **Diagnosis:** _____

Have you received previous Physical Therapy for this problem? (please circle) No OR Yes

If yes, when did you receive P.T. before? (dates) _____

Have you received other treatment for this problem? (please circle) No OR Yes

If yes, what types (medication, chiropractor, etc.)? _____

_____

Date of next your next doctor's appointment: _____

Medical History (please circle all that apply): heart problems / hypertension / diabetes hypoglycemia/ cancer / seizures / thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis / rheumatoid arthritis / hx of stroke / kidney problems depression / preeclampsia / osteoporosis / DVTs

Other:_____

Please list all surgeries and their dates: _____

_____

Gynecological History (fill in blanks or circle answer for all that apply):

Number of: pregnancies____ miscarriages_____ vaginal deliveries____ C-sections_____

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 heaviness / fibroids / cysts / endometriosis

Current Medications: _____

_____

Allergies: _____

Work Status: ☐ currently working ☐ on maternity leave ☐ not employed ☐ other:_____

Location / type of work: _____

How many hours at work:_____ Do you sit, stand, walk, other? _____

Emergency Contact:

Name: _____ Daytime phone #: (____)_____ -_____

How did you learn about us? ☐ friend ☐ internet ☐ advertisement ☐ physician ☐ nurse ☐ physician's assistant ☐ other:

Current Status: (Check by statement that applies and answer 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:_____

___ **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? No OR Yes

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 C-section, episiotomy or perineal tear?

No OR Yes (please specify)_____

___ **I recently experienced a miscarriage.**

Date of miscarriage: _____

Any other information:_____

Bowel / Bladder Symptoms: (Answer "yes" or "no." If "yes," describe the problem.)

Are you experiencing any problems with urinating or leaking urine?

_____

Are you experiencing any problems with bowel movements or leaking feces or gas?

_____

Current Symptoms:

What brings you in for therapy today?_____

Do you have pain? No OR Yes: Location(s)_____

Please shade in the areas pain on the drawing on the next page.

Describe how the pain feels:_____

When did pain first begin: _____

Are any of your normal activities limited by pain? No OR Yes:

If yes, please specify:_____

What makes your pain worse?:_____

What makes your pain feel better?:_____

Rate your pain on the following scale:

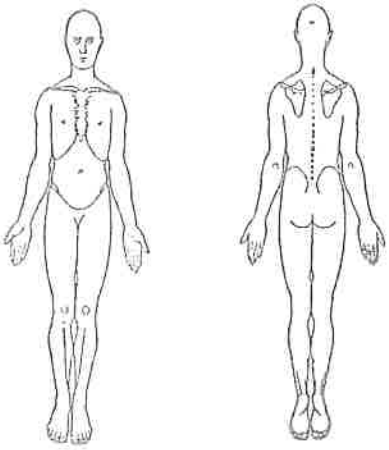
0=no pain at all, 5=moderate pain, 10=worst pain imaginable

At the worst (circle one): 0 1 2 3 4 5 6 7 8 9 10

On average: 0 1 2 3 4 5 6 7 8 9 10

Is there any other information you would like to share about your symptoms?

_____

Please shade in the areas where you are having pain:	Please tell us what you hope to achieve through therapy:
	

Fill out this section ONLY if 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.

_____ Yes, all the time
_____ Yes, most of the time
_____ No, not very often
_____ No, not at all

I have felt panicky or scared for no very good reason.

_____ Yes, all the time
_____ Yes, most of the time
_____ No, not very often
_____ No, not at all

I have been anxious or worried for no good reason.

_____ Yes, all the time
_____ Yes, most of the time
_____ No, not very often
_____ No, not at all

Therapist scoring Yes all 3pts, Yes most 2 pts, not often 1 pt, Not at all 0 pts. Added total multiply by (10/3). Refer score of 10 or greater

I attest that this information is true to the best of my knowledge and agree to physical therapy evaluation and treatment.

_____ _____

Patient Signature Date