Waldron's Peak Physical Therapy and Sirona Physical Therapy
Patient Intake Questionnaire

Please take a few minutes to fill out the following packet so that we are better able to assist you in your recovery. We look forward to working with you and thank you for choosing Waldron's Peak Physical Therapy and Sirona Physical Therapy for your physical therapy services.

Patient Information

Patient Name (Last, First, MI): _____

Preferred Name _____
☐ Miss ☐ Ms. ☐ Mrs. ☐Mr. ☐ Dr.

Preferred Pronoun: ☐He ☐She ☐They ☐Other_____

What is your current gender identity? (Please check all that apply)
☐Male ☐Female ☐Transgender (FTM) ☐Transgender (MTF) ☐Genderqueer
☐Intersex ☐Other ☐Prefer not to answer

D.O.B.:_____
Address:_____City:_____State:_____Zip: _____
Home Phone: (_____)_____ Cell Phone: (_____)_____Work Phone: (_____)_____
What phone can we leave voice messages on? Please circle.
Email: _____ Sex: M F Marital Status: _____

Would you like to receive TEXT appointment reminders? YES or NO

Guarantor Information (person responsible for paying bill/Insurance policy holder)

Guarantor Name (Last, First, MI):_____
Address: _____ City_____State_____Zip _____
Home Phone: (_____)_____ D.O.B. _____ Relationship to Patient: _____

Emergency Contact

Name (Last, First, MI):_____Relationship to Patient: _____
Phone #: (_____)_____

Physician Information

Referring Physician: _____ Phone #: (_____)_____
Family Physician:_____Phone #:( )_____
Additional Physician(s) involved with care: _____
Phone #: ( )_____/ Phone #: ( )_____

How did you hear about Waldron's Peak or Sirona Physical Therapy?

☐ Dr._____ ☐ Friend_____ ☐ Website_____ ☐ Other _____

Patient or Guardian Signature: _____ Date: _____

Waldron's Peak Physical Therapy Questionnaire

Please fill out the following form.

Describe the current problem that brought you here?_____

_____

When did your problem first begin? _____

Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

_____

Since that time is it: staying the _____same _____ getting worse getting better
Why or how?_____

If pain is present rate pain on a 0-10 scale 10 being the worst._____ Describe the nature of the pain (i.e. constant burning, intermittent ache)_____

_____

Describe previous treatment/exercises_____

_____

What are activities that cause or aggravate your symptoms. Check all that apply.

	Sitting greater than minutes		With cough/sneeze/straining
	Walking greater than minutes		With laughing/yelling
	Standing greater than minutes		With lifting/bending
	Changing position (ie-standing up)		With weather changes
	Light activity/housework		With triggers (running water, driving, etc.)
	Vigorous activity/exercise (running, weight lifting, jumping, etc.)		With nervousness/anxiety
	Sexual activity		Internal pelvic exams
	Other, please list:		

What relieves your symptoms?_____

_____

How has your lifestyle/quality of life been altered/changed because of this problem? _____

_____

Please Specify_____

Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____

_____

Waldron's Peak Physical Therapy Questionnaire

OB/GYN History, check all that apply:

	Childbirth vaginal deliveries #		Vaginal dryness
	Episiotomy #		Painful periods
	C-section #		Menopause, when?
	Difficult childbirth		Painful vaginal penetration
	Prolapse or organ falling out		Pelvic pain
Other, please describe:			

Bladder/Bowel Symptoms:

	Trouble initiating urine		Blood in urine
	Urinary intermittent/slow stream		Painful urination
	Trouble emptying bladder		Trouble feeling bladder urge/fullness
	Difficulty stopping urine stream		Current laxative use
	Trouble emptying bladder completely		Constipation/straining
	Straining or pushing empty bladder		Trouble holding back gas or feces
	Dribbling after urination		Recurrent bladder infections
	Constant urine leakage		
Other, please describe			

Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? __minutes, _____hours, _____not at all

The usual amount of urine passed is: ___small ___ medium___ large.

Frequency of bowel movements ____ times per day, _____times per week.

If constipation/leakage is present describe management techniques _____

_____

Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
___None present
___Times per month (specify if related to activity or your period)
___With standing for _____ minutes or _____hours.
___With exertion or straining
___Other

Skip questions if no leakage/incontinence

Bladder leakage - number of episodes		On average, how much urine do you leak?	
	No leakage		No leakage
	Times per day		Just a few drops
	Times per week		Wets underwear
	Times per month		Wets outerwear
	Only with physical exertion/cough		Wets the floor