Capitol Physical Therapy

Associated Physicians
Devoted Physicians, Trusted Care.

Intake Form

Are you a former CPT patient or a friend/family member of a former patient? ☐ Yes ☐ No

I. Personal Information

Name: _____ Date:_____

Occupation: _____ Employer: _____

Describe your usual exercise routine:_____

II. Medical History: Have you ever been diagnosed with or do you have any of the following conditions?
(Check all that apply)

☐ **None of these apply to me**

☐ Cancer
☐ Heart problems
☐ Chest pain/angina
☐ Circulation problems
☐ Blood clots
☐ Stroke
☐ Anemia
☐ Chemical dependency (i.e. alcoholism)
☐ Depression
☐ Anxiety
☐ Lung problems
☐ Tuberculosis
☐ Sexually transmitted disease/ HIV
☐ Rheumatoid Arthritis
☐ Arthritis
☐ Bladder/urinary tract infection
☐ Kidney problems/infection
☐ Cholesterol high/low
☐ Thyroid problems
☐ Diabetes
☐ Osteoporosis
☐ Multiple Sclerosis
☐ Epilepsy
☐ Hepatitis
☐ Ulcers
☐ Liver problems
☐ Allergies/asthma
☐ Pacemaker
☐ Blood thinners
☐ Fibromyalgia
☐ Broken bones
☐ Recent infection /illness (explain)
☐ Other

Past surgical history (list & date): _____

III. How did you hear about our clinic?

☐ My doctor's office ☐ I am referring myself for PT ☐ Family/friend/colleague recommended ☐ My insurance company said you were in my network ☐ I did a search on the internet ☐ My trainer ☐ Another PT sent me ☐ Other_____

Please tell us who we can thank for sending you our way:_____

IV. Current Symptoms Problem(s) you are here for: _____

What date (roughly) did your symptoms start? _____What do you think started your symptoms? _____

Are your symptoms related to a work injury? Yes No Or a motor vehicle accident? Yes No

Treatments so far for this problem (injections, chiropractic, etc.): _____

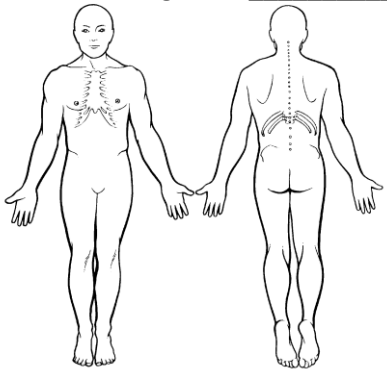
Have you had an X-ray, MRI, or other imaging for this problem? Yes No If yes, please list, including date: _____

Have you ever had this before? Yes No

If yes, when and how it was treated: _____

What is your personal goal for therapy? _____

Body chart: Please mark **all** areas where you feel symptoms on the chart to the right



What makes your symptoms **<u>better</u>**? _____

What make your symptoms **<u>worse</u>**? _____

On the scale below, please mark the number which best represents the severity of your pain over the past 24 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

SINCE YOUR SYMPTOMS BEGAN, have you noticed any of the following?

(Check all that apply)

- ☐ Fatigue
- ☐ Generalized muscle weakness
- ☐ Pain at night
- ☐ Leg swelling
- ☐ Weight loss/gain
- ☐ Difficulty maintaining balance when walking
- ☐ Changes in bowel or bladder function
- ☐ Changes in cognition
- ☐ Skin changes
- ☐ Numbness or tingling
- ☐ Falls
- ☐ Shortness of breath
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Heart palpitations
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Fainting
- ☐ Cough
- ☐ Chest pain especially with sweats
- ☐ Other
- ☐ **None of these apply to me**

How are you able to sleep at night? Fine Moderate difficulty Only with medication

During the past month have you been feeling down, depressed, or hopeless? Yes No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes No

Is depression or anxiety something you would like help with? Yes Yes, but not today No

Do you ever feel unsafe at home, or has anyone tried to hit or injure you in any way? Yes No

If you are over 65, how many falls have you had in the last 6 months? _____

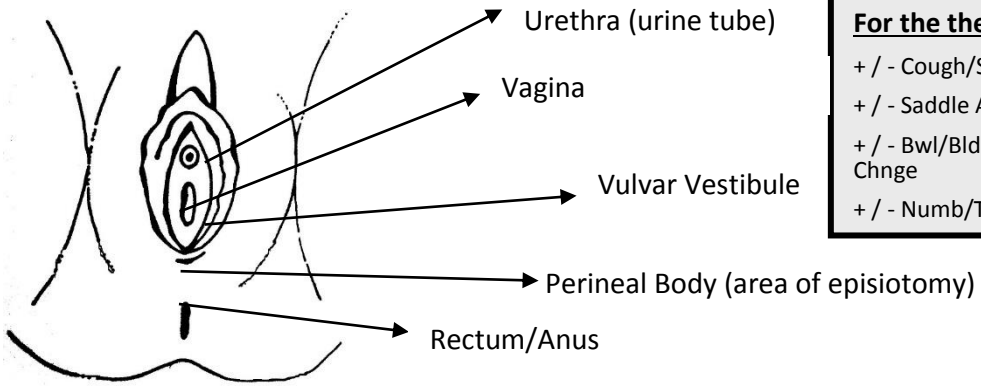
Are you taking any medications? ☐ No ☐ Yes ☐ Associated Physicians has my medications on file ☐ Med list is attached

Patient Signature:_____

Capitol Physical Therapy

FOR FEMALE PELVIC & WOMEN'S HEALTH PATIENTS:

Body Chart: **Please mark the areas where you feel pain**



For the therapist

+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Bldddr Chnge
+ / - Numb/Ting.

CHILDBEARING HISTORY:
Are you pregnant? Y / N If yes, due date?_____
# of pregnancies?_____
# of children?_____# of vaginal deliveries?_____
# of C-sections?_____# of episiotomies?_____
# of forceps deliveries?_____Tearing?_____

GYNECOLOGICAL HISTORY:
Date of last pap smear?_____

History of: (Check all that apply)
☐ Yeast infections? ☐ Candida? ☐ Genital Herpes? ☐ Lichens Simplex? ☐ Urinary tract infections? ☐ Blood in urine?
☐ Do you have any current infections or yeast?
☐ Recent change in vaginal discharge?
☐ Painful menstruation? ☐ If yes, is this new?
Date of last menstrual cycle? _____
Frequency of cycle?_____Length of cycle?_____
Any change in blood flow?_____
Age at menopause? _____ Bleeding since? Y / N / NA

Do you use: (Check all that apply)
☐ Bath salts? ☐ Spermicide? ☐ KY Jelly? ☐ Vaginal lubricants?
☐ Vaginal foams, sprays, or deodorants? ☐ Latex condoms?

URINARY/BLADDER HISTORY: (Check all that apply)
☐ Do you urinate more than one every 2 hours?
☐ Do you have a sense of "urgency" to urinate?
☐ Do you have difficulty initiating urine/hesitancy?
☐ Do you have symptoms of leaking urine?
☐ Do you have interstitial cystitis?
☐ Do you have painful urination?
☐ Recent change in urine color? ☐ Odor?
☐ Wake to urinate? If yes, how many times?_____

BOWEL HISTORY: (Check all that apply)
☐ Do you have irritable bowel syndrome (IBS)?
☐ Do you leak gas or feces?
☐ Do you have constipation?

PELVIC SURGERY HISTORY: (Check all that apply)
☐ Tubal ligation ☐ Gall bladder surgery? ☐ Laparoscopy?
☐ Abdominal or vaginal hysterectomy? ☐ Bladder surgery?
☐ Pelvic surgery? ☐ Vaginal surgery/laser? ☐ Vulvar surgery?

CURRENT SEXUAL ACTIVITY:
☐ Sexually Inactive due to PAIN ☐ Sexually active
☐ Sexually inactive for other reasons

If you are sexually active, continue with this section:
☐ No pain with intercourse
☐Pain with intercourse, able to complete sex
☐ Pain with intercourse disrupts or prevents sex
☐ Pain with intercourse prevents any attempt to have sex
☐ Tolerate manual or oral stimulation only/no penetration

CHECK ALL THE ACTIVITIES THAT CAUSE OR INCREASE PAIN:
☐ Gynecological examination with speculum ☐ Masturbation
☐ Urination after intercourse ☐ Urination in general
☐ Tampon insertion ☐Tampon removal ☐ Wearing pads
☐ Partner manual stimulation ☐ Friction with clothing
☐ Finger insertion into vagina ☐Oral stimulation ☐ Sports activity ☐ Other:_____

CHECK THE WORDS THAT DESCRIBE YOUR PAIN:
☐ Hot ☐ Burning ☐ Scalding ☐ Searing ☐ Sharp ☐ Cutting
☐ Tearing ☐ Tiring ☐ Exhausting ☐ Frightful ☐ Punishing
☐ Grueling ☐ Suffocating ☐ Sickening ☐ Annoying
☐ Troublesome ☐ Miserable ☐ Intense ☐ Unbearable
☐ Discomforting ☐ Other:_____
_____

WHAT MAKES YOUR PAIN BETTER? (Check all that apply)
☐ Heating pad ☐ Ice pack ☐ Resting in bed ☐ Resting in chair ☐ Medication ☐ Cream ☐ Abstaining from sexual intercourse ☐ Not using tampons ☐ Not wearing tight clothes
Other_____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?
____None or:_____
Medication: Y / N Has it helped? Y / N
Surgery? Y / N Did it help? Y / N
Physical Therapy? Y / N

SKIN CONDITIONS: (Check all that apply)
☐ Eczema? ☐ Contact dermatitis ☐ Psoriasis?
☐ Other? _____

FLUID INTAKE: How many of each do you drink every day?
____8 ounce glasses of water ___cans of diet soda ____cans of regular soda ____8 ounce cups of regular coffee
____8 ounce cups of decaffeinated coffee ____8-ounce cups/glasses of tea ____16-ounce cans of beer ____glasses of wine
____glasses of liquor ____8-ounce glasses of milk ____8-ounce glasses of juice Other:_____