Root Physical Therapy - Initial Visit Intake Form

NEW CLIENTS WILL RECEIVE THIS FORM VIA EMAIL TO FILL OUT ONLINE ONCE YOUR "INITIAL EVAL APPOINTMENT" HAS BEEN SCHEDULED

–THE BELOW IS AS A FORM PREVIEW FOR POTENTIAL CLIENTS–

At the present time, would you say your health is:

Excellent Good Fair Poor

What is your chief complaint or reason for coming to physical therapy?*

How long has this been going on?

What do you hope to get out of physical therapy?*

Which medical professionals have you seen for this condition?
Family Doctor
Orthopaedic Doctor
OBGYN
Urologist
Neurologist
Chiropractor
Physical Therapist
Acupuncturist

Have you had any diagnostic or medical procedures or surgeries for this condition? If yes, which types? What were the results?

Please list any past surgeries or hospitalizations with dates here.

If you have pain, what is your pain at BEST In the last 72 hours? (0 = none, 10 = worst imaginable)

If you have pain, what is your pain at BEST In the last 72 hours? (0 = none, 10 = worst imaginable)

0 1 2 3 4 5 6 7 8 9 10

If you have pain, what is your pain at WORST In the last 72 hours? (0 = none, 10 = worst imaginable)

If you have pain, what is your pain at WORST In the last 72 hours? (0 = none, 10 = worst imaginable)

0 1 2 3 4 5 6 7 8 9 10

Root Physical Therapy - Initial Visit Intake Form

Describe your current symptoms/pain (select all that apply):

Describe your current symptoms/pain (select all that apply):
Sharp stabbing dull aching radiating sore throbbing

What makes your pain worse?

What makes your pain lessen?

Do you currently have or have a history of the following conditions?
Asthma/Emphysema/Other Breathing Disorder
Arrhythmia/Chest Pain/Cardiac Condition/Pacemaker
Cancer
Autoimmune Disease
Stroke/TIA/Traumatic Brain Injury
Bowel or Bladder Changes
Unexplained Weight Loss or Gain
High Blood Pressure
Anxiety/Depression/Emotional or Psychological Condition
Headache/Migraine/TMJ
Seizure Disorder
Hepatitis/HIV
Other Current or Past Sexually Transmitted Disease
Endometriosis
Polycystic Ovary Syndrome
Irritable Bowel Syndrome
Inflammatory Bowel Disease
Uterine Fibroids
Ovarian Cysts
Infertility or Fertility Issues
Osteoporosis/Osteopenia
Fracture
Diabetes
Balance Difficulty/Falls
Neurological Disease
Vision/Hearing/Speech Disturbance

If you clicked a box above, please elaborate here:

Any other past medical history that I should know about (surgeries, procedures, conditions)?

Please list any medications that you are taking and reason for taking.

Over the counter: Prescription:

Any known allergies (medicines, adhesives, latex, etc)?

Root Physical Therapy - Initial Visit Intake Form

What do you do for a living?

What do you do for fun?

What do you do for exercise and how often?

How many hours of sleep do you get each night?

Pelvic Floor Section - *SKIP THIS SECTION IF NOT APPLICABLE - jump to end to sign*

The pelvic floor has many different functions including core stability, pelvic organ support, bladder and bowel control, and sexual function. The following questions provide essential information to the overall function of your pelvic floor. Please answer to the best of your ability and skip any questions that are not applicable.

Birth History

Number of pregnancies:

Number of vaginal deliveries, dates and birth weights:

Number of cesarean deliveries, dates and birth weights:

Please check the following boxes if applicable.

Bladder Symptoms

Do you have frequent urinary tract infections?
Do you have burning/pain with urination?
Do you have difficulty starting a stream of urine?
Do you strain to empty your bladder?
Do you feel unable to empty your bladder fully?
Do you have a strong urge with urination?
Do you have difficulty making it to the bathroom in time?
Do you urinate more frequently than every two hours?
Do you wake up to urinate during the night?
Do you wet the bed?
Do you wear incontinence pads/liners?

Do you lose urine when you:

Cough
Sneeze
Laugh
Run
Jump

Root Physical Therapy - Initial Visit Intake Form

Lift objects
On the way to the bathroom
Have a strong urge to urinate
Hear running water

What volume of urine do you usually leak?

What volume of urine do you usually leak?
N/A A few drops Enough to wet underwear Enough to wet pants Enough to wet floor

Bowel Symptoms
Do you have a history of constipation/straining to have a bowel movement?
Do you have pain with bowel movements?
Do you have a history of hemorrhoids or anal fissures?
Do you have a feeling of incomplete emptying with bowel movements?
Do you have frequent bloating?
Do you leak or stain feces?
Do you wear incontinence pads?
Do you include fiber in your diet? (Supplements, foods)
Do you have diarrhea often?
Do you take laxatives/enema regularly?
Do you leak gas by accident?
Do you have a very strong urge to move your bowels?

Dietary
How much plain water do you drink each day in ounces?
Do you drink caffeine? How much and what kind?

Please check the following boxes that apply
Do you have a history of sexual abuse or trauma?
Are you having regular periods or menstrual cycles?
Do you experience vaginal dryness?
Do you have feelings of heaviness or pressure in your vagina?
Do you have a feeling of something falling out of your vagina or rectum?
Have you ever been told you have a prolapse?

Pain
Do you have pain with gynecological pelvic exams?

Do you have pain with tampon use?

Do you have pain with sexual Intercourse? With initial penetration, deep penetration or external stimulation, or something else?

Do you have pain with orgasm?

Do you have pain after sexual intercourse? How long does it last?

Do you have tailbone pain? When?

Do you have abdominal pain?

Do you have groin or hip pain?

Do you have low back or leg pain?

Do you have painful or heavy periods?

PLEASE MAKE SURE TO SIGN BELOW:

You made it! Whew!

Signature*