Root Physical Therapy & Pilates
2907 12th Ave S, #4
Nashville, TN 37204
(615) 933-7025

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 --

Patient Intake Questionnaire

Name: ____________________________ Date of Birth: ___________ Today's Date: _______

Sex: M / F Occupation: ________________

Referring Physician (or Primary Care): ______________ Diagnosis (if applicable): ___________

Phone number: ____________________ Email: ______________________________________

Address: ____

Emergency contact (name / number): ____

Please answer the following questions.

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

   Excellent __ Very good __ Fair __ Poor __

2. What is your primary problem/condition for being here? ___________________________________

   ____

3. How/when did your problem begin?

   ____

4. If your condition is painful, please rate your pain on a scale from 0-10 with 0 being no pain and 10 being pain for which you would go the emergency room (circle the appropriate number):

CURRENT PAIN 0 1 2 3 4 5 6 7 8 9 10 **WORST PAIN** 0 1 2 3 4 5 6 7 8 9 10

5. If your condition is painful, please rate your pain on a scale from 0-10 with 0 being no pain and 10 being pain for which you would go the emergency room (circle the appropriate number):

CURRENT PAIN 0 1 2 3 4 5 6 7 8 9 10 **WORST PAIN** 0 1 2 3 4 5 6 7 8 9 10

6. Describe your current symptoms/pain :

- ☐ Sharp
- ☐ Dull
- ☐ Sore
- ☐ Stabbing
- ☐ Aching
- ☐ Radiating
- ☐ Other:______________________

7. What makes your symptoms worse?

 ____

8. What makes your symptoms better?

 ____

9. Do you experience any urinary symptoms/issues?
    a. No.
    b. Yes (If Yes, select all that apply)
        - ☐ Urinary urgency (feeling like you need to urinate all the time)
        - ☐ Urinary frequency (urinating more than every 2 hours during the day)
        - ☐ Nocturia (getting up more to urinate more than 1-2x at night)
        - ☐ Urinary stress incontinence (SUI) - leakage with coughing, sneezing, laughing, and/or jumping/exercising
        - ☐ Urge incontinence - leakage en route to the bathroom
        - ☐ Post void dribble - leakage after get up from urinating
        - ☐ Pain or spasms with urination

10. Do you experience any bowel symptoms?
    a. No
    b. Yes (If Yes, select all that apply)
        - ☐ Bowel leakage or fecal smearing
        - ☐ Difficulty controlling gas
        - ☐ Constipation and/or straining to defecate
        - ☐ Pain with bowel movements

11. Do you experience any pain with intercourse?
    a. No
    b. Yes

12. Do you experience any other issues with intercourse (i.e.decreased sex drive, decreased sensation, inability to orgasm, etc)? ____

13. Have you had similar problems/conditions before? If so, please describe: ____________________

 ____

14. Does your problem/condition affect your function? If so, in what way? ______________________

 ____

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15. Have you had any treatment for your problem/condition recently or in the past? If so, what?

    ____

16. Which, if any, previous treatments helped? _______________________________________
17. When did you first see a physician for your problem? _________________________________
18. Has your physician done any tests or procedures for this problem (x-ray, MRI, etc)? If so, what?

    ____

19. What medications are you currently taking? *(Over-the-counter and/or prescription)*

    ____

    ____

20. List and date any major illnesses, surgeries, and hospitalizations: ______________________

    ____

    ____

21. Please mark below if you currently have or have had any of the following:

___Heart condition
___Pulmonary disease
___Bowel/bladder problems
___Chest pain/pressure
___Shortness of breath
___Ulcer
___High blood pressure
___Asthma
___Diabetes
___Low blood pressure
___Allergies

___Seizures
___Circulation problems
___Blackouts
___Kidney disease
___Pacemaker
___Difficulty sleeping
___Hepatitis
___Stroke
___Anxiety
___Multiple sclerosis
___Blood clot

___Depression
___Frequent/severe HAs
___Thyroid problems
___Anemia
___Osteoporosis
___Cancer
___Menstrual irregularities
___Osetoarthritis
___Rheumatoid arthritis
___Chemical dependency
___Other (Please list):

22. Have you recently noted any of the following:

YES NO Weight loss/gain
YES NO Weakness
YES NO Fever/chills/sweats
YES NO Numbness or tingling

YES NO Nausea/vomiting
YES NO Fatigue
YES NO Dizziness/lightheadedness
YES NO Pregnant (if applicable)

23. What are your goals of therapy? ____

____