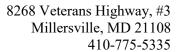




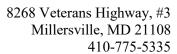
Intake Questionnaire

Name:	Date:	Phone:		
Address:				
Date of Birth: Age:				
Primary Doctor:	Emai	1:		
		?		
When did the problem begin?y	ears agom	onths ago		
Previous treatment or therapy (Describ	e):			
n.:				
Pain Location of pain				
Level of pain (0 = no pain, 10 = worst	pain)			
Current Pain	P *****)			
Best Pain				
Worst Pain				
Activities that make symptoms worse.	(Check all that app	oly)		
☐ Sitting more than minutes	□Kneelin	g		
☐ Walking more than minutes	□Coughi	☐ Coughing/sneezing/straining		
Standing more than minutes				
☐ Changing positions (sit to stand)	_	us activity/exercise (run/jump/weights)		
□Lifting/Bending	g □ Sexual activity			
☐ Light activity (housework)	□Other:_			
□Squatting				
Things that make symptoms better. (C	11 0/			
☐Heat		tion		
□Ice	□Other:_			
□Rest				
□Elevation				



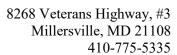


Medication	Reason	Dosage	Been taking since			
Allergies to medications	s, food or other					
Past Medical History (P	lease check all th	at apply)				
□Cancer		☐Diabetes Type I or	II			
☐ Heart Conditions		□Headaches				
□Stroke		☐ Sexually Transmit	ted Disease			
☐ High Blood Pressure		☐Physical or Sexual				
□Anemia			□Hypo/Hyperthyroidism			
□Seizures		☐Hearing Loss				
□Fibromyalgia		□Vision/Eye Condit	ions			
□Osteoporosis		☐Kidney Conditions				
☐ Concussion		☐Neurological Cond	litions			
□Arthritis		□Poor Balance/Falls				
□Depression		□Pacemaker				
□Anxiety		☐Bleeding Disorders	s or Clots			
□Asthma			onditions (IBS/Crohn's)			
□Fractures			ency (Alcohol or Drugs)			





Surgical History (Related to spine, joint, brain, bladder/prostate, pelvis, abdomen or other)					
Special Test, Procedures or Imaging Performed (Including, but not limited to: X-ray, MRI, CT scan, Myelogram, EMG, Nerve Conduction Test, Colonoscopy, Urodynamics Test, Cystoscopy, Injections)					
Exercise and Activities (Sta	te type and frequenc	y)			
Pelvic Questionnaire					
Fluid Intake (# of cups/day) Water Coffee (caff/d Beer Liquor	lecaff) Tea_	Soda	Juice	_ Wine	
Bladder History Frequency of urination: Trouble starting your stream Slow or hesitant stream? Loss of sensation of bladder	?)(# tin Difficulty or str Pain or burning Dribbling after	raining to empt with emptying	•	
Urine leakage?		Freq. of leakage	_		
Pad usage for urine?			Types of Pads	S	
Leakage triggers (check all the Coughing ☐ Lifting ☐ Intercourse ☐ Other (please describe)	☐Sneezing ☐Exercise ☐On way to to	ilet	☐ Laughing ☐ Sit to stand ☐ Key in door	r	
Bowel History Frequency of bowel movements Straining to empty bowel or Supplements for bowel regula Trouble holding back gas? Fecal incontinence or seepag	constipation? arity				





If Yes, please state frequency (times per day/week/month) and triggers					
Pelvic Questions					
Are you sexually active?					
Do you experience pain or discomfort with intercourse? (If yes, please describe)					
Do you ever have the sensation of something falling	ng out, pelvic heaviness or pressure?				
Do you ever experience pelvic or lower abdominal	pain? (If yes, please describe)				
OB/Gyn History (Females only) Date of last menstrual cycle # Deliveries	Painful/heavy periods? # Miscarriages				
Vaginal Deliveries (Please list dates and birth weig	ghts)				
Cesarean Sections (Please list dates and birth weig	hts)				
# Episiotomies # Tears (grade) #Vac					
Delivery Complications					
Males Only					
	Erectile dysfunction?				
Other	<u> </u>				