8268 Veterans Highway, #3
Millersville, MD 21108
410-775-5335

Intake Questionnaire

Name:______________________________ Date:___________ Phone:______________________
Address:____
Date of Birth: __________ Age: _____ Insurance:______________Referred by:______________
Primary Doctor:_____________________________ Email:_______________________________
Please describe the current problem that brought you here?________________________________
____
____
When did the problem begin? ______years ago _____months ago
Previous treatment or therapy (Describe):_______________________________________
____
____

Pain

Location of pain____
Level of pain (0 = no pain, 10 = worst pain)

Current Pain	0	1	2	3	4	5	6	7	8	9	10
Best 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

Activities that make symptoms worse. (Check all that apply)

- ☐Sitting more than _____ minutes
- ☐Walking more than _____ minutes
- ☐Standing more than _____ minutes
- ☐Changing positions (sit to stand)
- ☐Lifting/Bending
- ☐Light activity (housework)
- ☐Squatting
- ☐Kneeling
- ☐Coughing/sneezing/straining
- ☐Laughing/yelling
- ☐Vigorous activity/exercise (run/jump/weights)
- ☐Sexual activity
- ☐Other:__________________________________
  ____

Things that make symptoms better. (Check all that apply)

- ☐Heat
- ☐Ice
- ☐Rest
- ☐Elevation
- ☐Medication____________________________
- ☐Other:________________________________
  ____

Blue Sky WELLNESS
Pelvic, Orthopedic & Visceral Physical Therapy

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Medical History

Medication	Reason	Dosage	Been taking since

Allergies to medications, food or other

___

___

Past Medical History (Please check all that apply)

- ☐Cancer
- ☐Heart Conditions
- ☐Stroke
- ☐High Blood Pressure
- ☐Anemia
- ☐Seizures
- ☐Fibromyalgia
- ☐Osteoporosis
- ☐Concussion
- ☐Arthritis
- ☐Depression
- ☐Anxiety
- ☐Asthma
- ☐Fractures
- ☐Diabetes Type I or II
- ☐Headaches
- ☐Sexually Transmitted Disease
- ☐Physical or Sexual Abuse
- ☐Hypo/Hyperthyroidism
- ☐Hearing Loss
- ☐Vision/Eye Conditions
- ☐Kidney Conditions
- ☐Neurological Conditions
- ☐Poor Balance/Falls
- ☐Pacemaker
- ☐Bleeding Disorders or Clots
- ☐Gastrointestinal Conditions (IBS/Crohn’s)
- ☐Chemical Dependency (Alcohol or Drugs)

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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 (State type and frequency)

____
____
____

Pelvic Questionnaire

Fluid Intake (# of cups/day)
Water______ Coffee (caff/decaff) ______ Tea______ Soda_____ Juice_____ Wine________
Beer_______ Liquor______ Other______

Bladder History
Frequency of urination:________(# times per day) ________(# times per night)
Trouble starting your stream? Yes/No
Difficulty or straining to empty? Yes/No
Slow or hesitant stream? Yes/No
Pain or burning with emptying? Yes/No
Loss of sensation of bladder urge? Yes/No
Dribbling after urination? Yes/No
Urine leakage? Yes/No
Freq. of leakage (per day/week/mon)________
Pad usage for urine? Yes/No # Pads per day______________ Types of Pads______________
Leakage triggers (check all that apply)
☐Coughing ☐Sneezing ☐Laughing
☐Lifting ☐Exercise ☐Sit to stand
☐Intercourse ☐On way to toilet ☐Key in door
☐Other (please describe)____

Bowel History
Frequency of bowel movements (per day/week) ____
Straining to empty bowel or constipation? Yes/No
Supplements for bowel regularity ____
Trouble holding back gas? Yes/No
Fecal incontinence or seepage? Yes/No

If Yes, please state frequency (times per day/week/month) and triggers ____________________
____

Pelvic Questions

Are you sexually active? Yes/No

Do you experience pain or discomfort with intercourse? Yes/No (If yes, please describe)_______
____

Do you ever have the sensation of something falling out, pelvic heaviness or pressure? Yes/No

Do you ever experience pelvic or lower abdominal pain? Yes/No (If yes, please describe)______
____

OB/Gyn History (Females only)

Date of last menstrual cycle ________________ Painful/heavy periods? Yes/No

Pregnancies ____________ # Deliveries ___________ # Miscarriages ____________

Vaginal Deliveries (Please list dates and birth weights)__________________________________
____
____

Cesarean Sections (Please list dates and birth weights)__________________________________
____
____

Episiotomies____ # Tears (grade)_____ #Vacuum deliveries____ #Forceps deliveries_____

Delivery Complications____

Males Only

Prostate Disorders________________________________ Erectile dysfunction? Yes/No

Other____