**Name:** ______________________ **Age:**_____ **Today's Date:** ______________

Describe the problem that brings you to therapy:______________________________________________

Date problem began:______________________________________________

How did your problem or injury occur? ______________________________________________

Have you had treatment for this problem? (If so, please describe) ______________________________________________

Please list any healthcare professional whose care you're currently under (i.e. Medical Doctor, Osteopath, Dentist, Psychiatrist/Psychologist, Chiropractor, etc.)______________________________________________

Before this problem began, how well were you functioning? ______________________________________________

Since then, has your problem: ❑ Worsened ❑ Improved ❑ Stayed same

What do you hope to achieve as a result of this treatment?______________________________________________

Do you have pain? ❑ YES ❑ NO → If yes, please indicate areas and type of pain with the following symbols ON THE BODY CHART BELOW.

SHARP
**XXXX**

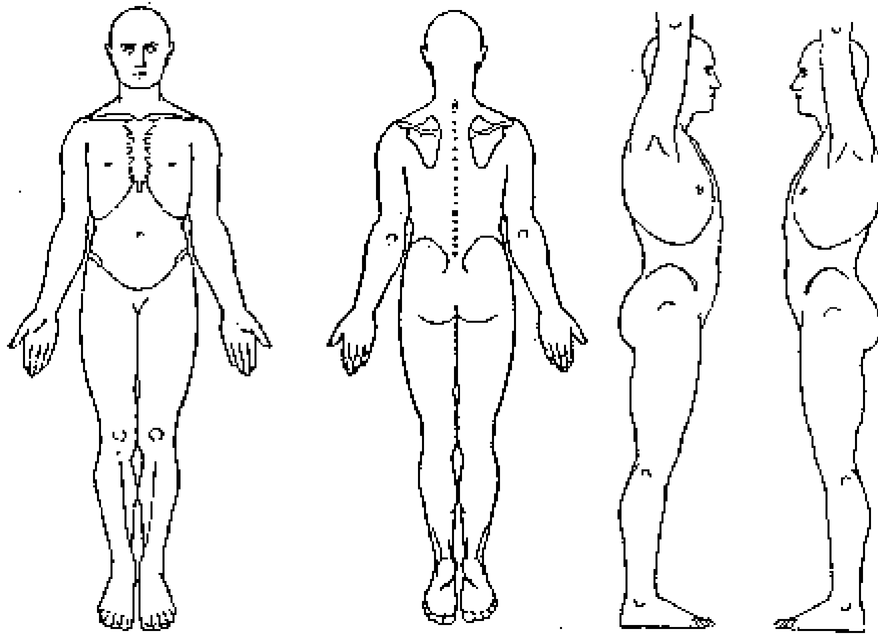
DULL
**OOOOOO**

ACHING
✓✓✓✓✓✓

NUMBNESS
□□□□□

TINGLING
••••••••••••••••••••••

BURNING
// // // // //



Is pain **constant** or does it **come and go**? (circle one)

What activities INCREASE pain/symptoms?______________________________________________

What activities DECREASE pain/symptoms?______________________________________________

Please rate your current pain on the following pain scale: (Circle the number.)

| 0 (none) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 (Severe) |
|---|---|---|---|---|---|---|---|---|---|---|

Have you had any previous orthopedic problems? If yes, specify:______________________________________________

What is your occupation? ______________________________________________

What activities does your work require? (ex: lifting, prolonged sitting, standing, etc.)______________________________________________

Are you currently working? ❑ YES ❑ NO If not, when was your last day of work? ______________

Living arrangement: ❑ Alone ❑ With others ______________________________________________

Describe what you do to keep physically fit:______________________________________________

09.0002

*Olathe Medical Center*
20333 West 151st Street
Olathe, Kansas 66061

**MEN'S HEALTH PHYSICAL THERAPY INTAKE QUESTIONNAIRE**



2.4.2011; Rehab

**O.M.C. No. 1684**

PLACE

PATIENT LABEL

HERE

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
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ❑ YES ❑ NO

**Please indicate (X) which of the following activities you have difficulty with or are compensating for:**

____ Dressing ____ Hygiene (bathing, toileting, grooming) ____ Household activities _____ Sleeping

____ Walking ____ Skills with Dominant Arm _____ Work Activities ____ Sitting ____

____ Sexual Intercourse – if so, is it 1) with penetration ❑ Yes ❑ No 2) with thrust ❑ Yes ❑ No

Other ________________________________________________________________________________

**Past Medical History: Do you have any previous history of the following conditions?**

| CONDITIONS: | YES | NO |
|---|---|---|
| Pelvic or tailbone trauma | | |
| Currently Sexually Active | | |
| Sexually Transmitted Disease | | |
| Frequent Bladder Infections | | |
| Frequent Yeast Infections | | |
| Hemorrhoids/Fissures | | |
| IBS (Irritable Bowel Syndrome) | | |
| Fibroids/Cysts | | |

History of abuse (physical or emotional):

What is your learning preference? ❑ Written ❑ Verbal ❑ Video ❑ Other:
Do you have an Advanced Directive? ❑ YES ❑ NO
If yes, can you provide it? ❑ YES ❑ NO If no, do you need more information? ❑ YES ❑ NO

Are you currently receiving any home health services? ❑ YES ❑ NO

Have you taken steroids for a prolonged period of time? ❑ YES ❑ NO

Have you had any tests in the past 6 to 12 months? (X-Ray, CT Scan, MRI, EMG, ECG, etc) ___________________________

Have you recently noted (**within the past 3 months**):

| | | | | | |
|---|---|---|---|---|---|
| Weight loss/gain | YES | NO | Weakness | YES | NO |
| Nausea/Vomiting | YES | NO | Fever/chills/sweats | YES | NO |
| Dizziness/lightheadedness | YES | NO | Numbness or tingling | YES | NO |
| Fatigue | YES | NO | | | |

In the space below, please tell us anything else you think your therapist will need to know: ______________________________

## If you have any bowel or bladder issues, please answer the following:

| | |
|---|---|
| How many times do you urinate during the day?<br>❑ 1-3 times ❑ 10-15 times<br>❑ 4-7 times ❑ more than 15 times<br>❑ 7-10 times | Type of protection? ____Pad changes/day<br>❑ Liner or minipad ____________________________<br>❑ Maxi or bladder pad _________________________<br>❑ Diaper or Depends __________________________ |
| How many times do you urinate at night?<br>❑ None / Rarely<br>❑ Once<br>❑ 2-3 times<br>❑ More than 3 times | Do you have frequent bladder infections?<br>❑ Yes ❑ No |
| Is urinary sensation present?<br>❑ Yes ❑ No | What causes you to lose urine?<br>❑ Cough, laugh, or sneeze ❑ Other _____________<br>❑ Physical activity / exercise ___________________<br>❑ Approaching a bathroom ___________________<br>❑ Hand washing ______________________________<br>❑ Intercourse ________________________________ |
| How long can you hold urine once you have an urge?<br>❑ As long as I need to<br>❑ For about 30 minutes<br>❑ For a few minutes (2-5 minutes)<br>❑ For less than 2 minutes<br>❑ Cannot tell when full | Do you have difficulty during urination?<br>❑ Difficulty starting flow ❑ Straining to finish flow<br>❑ Strong urge / frequency ❑ Slow, dribbling stream<br>❑ Abnormal Color ❑ Other: ____________ |
| When you urinate, do you feel it is a<br>❑ Small ❑ Medium ❑ Large amount? | Frequency of bowel movements: _______________<br>Frequent Constipation? ❑ Yes ❑ No<br>Frequent Diarrhea? ❑ Yes ❑ No<br>Regular Laxative Use? ❑ Yes ❑ No<br>Bowel sensation present? ❑ Yes ❑ No<br>Describe the shape of your stool: _______________ |
| Do you feel you empty your bladder completely?<br>❑ Yes ❑ No | |
| Are you able to stop your flow of urine by squeezing your pelvic floor muscles? ❑ Yes ❑ No | Do you have any fecal leakage: ❑ Yes ❑ No<br>Fecal leakage amount?<br>❑ Small ❑ Medium ❑ Large<br>Do you wear a pad for this? ❑ Yes ❑ No |
| Do you have any urinary leakage? ❑ Yes ❑ No<br>(Please fill in the blank that best quantifies your frequency of leakage.)<br>______ times /day ______ times/night<br>______ times/week ______ times/month | How many 8 oz glasses of water do you drink per day? ______ |
| How much urine do you lose during an accident?<br>❑ A few drops (small amount)<br>❑ Enough to spot clothing / pad (medium amount)<br>❑ Most or all of bladder (large amount) | Which "bladder irritants do you consume? Quantity?<br>❑ Alcohol ______________________________<br>❑ Caffeinated beverages ____________________<br>❑ Decaffeinated beverages ___________________<br>❑ Chocolate ___________________________<br>❑ Citric juices __________________________<br>❑ Spicy foods___________________________<br>❑ Milk ______________________________ |

Please let us know about any other bowel or bladder problems that you are experiencing in the space below.

______________________________________________________________________________