★★★ **Are you currently receiving <u>ANY</u> home health services? ❑ YES ❑ NO**

Name: _____ Age:_____ Today's Date: _____

Have you had any outpatient physical therapy, occupational therapy, and/or speech-language pathology for any reason since January 1 of this year? ❑ YES ❑ NO
If yes, please describe: _____
Describe the problem that brings you to therapy:_____
_____
_____
Date problem began:_____
What is your goal as a result of this treatment?_____

Do you have pain? ❑ YES ❑ NO → If yes, please rate your pain on the following pain scale: (Circle the number.)

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

If you do have pain, please write where your pain is located: _____
_____
Describe what you do to keep physically fit:_____

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 ____ Other _____
____ Sexual Intercourse – if so, is it 1) with ejaculation ❑ Yes ❑ No 2) testicular pain ❑ Yes ❑ No
3) penile pain ❑ Yes ❑ No 4) pain with bowel movement ❑ Yes ❑ No

Other _____

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		
Prostatitis		

CONDITIONS:	YES	NO
Hemorrhoids/Fissures		
IBS (Irritable Bowel Syndrome)		
Inflammatory Bowel Disease (e.g., Crohn's Disease)		

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) _____

<u>Have you recently noted (**within the past 3 months**):</u>

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

<u>Languages you speak</u>: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other: _____
<u>Preferred language for discussing healthcare:</u> ❑ English ❑ American Sign Language ❑ Spanish ❑ Other: _____
<u>Preferred method of communication:</u> ❑ Verbal ❑ Sign Language ❑ Written ❑ Video ❑ Other: _____

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

➔➔➔ OVER ➔➔➔

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

How many times do you urinate during the day?
❑ 1-3 times ❑ 10-15 times
❑ 4-7 times ❑ more than 15 times
❑ 7-10 times

How many times do you urinate at night?
❑ None / Rarely
❑ Once
❑ 2-3 times
❑ More than 3 times

How long can you hold urine once you have an urge?
❑ As long as I need to
❑ For about 30 minutes
❑ For a few minutes (2-5 minutes)
❑ For less than 2 minutes
❑ Cannot tell when full

When you urinate, do you feel the amount is:
❑ Small ❑ Medium ❑ Large

Do you feel you empty your bladder completely?
❑ Yes ❑ No

Are you able to stop your flow of urine by clenching your pelvic floor muscles? ❑ Yes ❑ No

Do you have any urinary leakage? ❑ Yes ❑ No
(Please fill in the blank that best quantifies your frequency of leakage.)
_____ times /day _____ times/night
_____ times/week _____ times/month

How much urine do you lose during an accident?
❑ A few drops (small amount)
❑ Enough to spot clothing / pad (medium amount)
❑ Most or all of bladder (large amount)

Do you have any known food allergies/sensitivities such as:
❑ Gluten ❑ Eggs
❑ Dairy ❑ Artificial dyes or sweeteners
❑ Soy ❑ Other: _____
❑ Peanuts ❑ Unknown

Do you experience:
❑ Frequent gas
❑ Bloating
❑ Abdominal pain

Type of protection? ____Pad changes/day
❑ Bladder pad _____
❑ Diaper or Depends _____

Do you have frequent bladder infections?
❑ Yes ❑ No

What causes you to lose urine?
❑ Cough, laugh, or sneeze ❑ Other _____
❑ Physical activity / exercise _____
❑ Approaching a bathroom _____
❑ Hand washing _____
❑ Intercourse
_____

Do you have difficulty during urination?
❑ Difficulty starting flow ❑ Straining to finish flow
❑ Strong urge / frequency ❑ Slow, dribbling stream
❑ Abnormal Color ❑ Other: _____

Frequency of bowel movements: _____
Frequent Constipation? ❑ Yes ❑ No
Frequent Diarrhea? ❑ Yes ❑ No
Regular Laxative Use? ❑ Yes ❑ No
Bowel sensation present? ❑ Yes ❑ No
Describe the shape of your stool: _____

Do you have any fecal leakage: ❑ Yes ❑ No
Fecal leakage amount?
❑ Small ❑ Medium ❑ Large
Do you wear a pad for this? ❑ Yes ❑ No

How many 8 oz glasses of water do you drink per day?
_____

Which "bladder irritants" do you consume? Quantity?
❑ Alcohol _____
❑ Caffeinated beverages _____
❑ Decaffeinated beverages _____
❑ Chocolate _____
❑ Citric juices _____
❑ Spicy foods_____
❑ Milk _____

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

_____

➔➔➔ OVER ➔➔➔

Past Medical History: Do you have ANY previous history of the things listed below?

CONDITIONS:	YES	NO	CONDITIONS:	YES	NO
High Blood Pressure			Pacemaker		
Heart Condition			Seizures		
Stroke(s)			Cancer		
Metal Implants			Shortness of Breath		
Diabetes			Asthma		
Dizziness			Persistent Night Pain		
Light Headedness			Frequent/Severe Headaches		
Excessive Fatigue			**Unexplained** Weight Loss		
Broken Bones (fractures)			Past or Current Bowel/Bladder dysfunction		
Fibromyalgia			Gynecological Issues		
Arthritis			Vaginal/Cesarean Birth (Number: _____)		
Thyroid Problems			↳ Did you have any back pain with your pregnancy or after childbirth?		
Kidney Problems					
Blood Clots and/or Poor Circulation			Other:		

Staff Initials	Date	Time	ALLERGIES Do you have any allergies? ☐ No ☐ Yes, please list:	REACTION(S)

Staff Initials	Date	Time	OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Do you have any other diagnoses &/or significant conditions? ☐ No ☐ Yes, please list:

Staff Initials	Date	Time	PREVIOUS PROCEDURES / SURGERIES Do you have any previous procedures or surgeries? ☐ No ☐ Yes, please list:

Staff Initials	Date	Time	CURRENT MEDICATIONS ☐ See attached list of medications that the patient provided. Are you currently taking any medications, including herbals? ☐ No ☐ Yes, please list:

INITIALS	STAFF SIGNATURE	INITIALS	STAFF SIGNATURE

TIME: _____ DATE: _____ PATIENT SIGNATURE: _____