Blue Sky WELLNESS
Pelvic, Orthopedic & Visceral Physical Therapy

497 Ritchie Highway
Suite 1A&B
Severna Park, MD 21146
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
Best Pain
Worst Pain

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:_____
_____

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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? Difficulty or straining to empty?
Slow or hesitant stream? Pain or burning with emptying?
Loss of sensation of bladder urge? Dribbling after urination?
Urine leakage? Freq. of leakage (per day/week/mon)_____
Pad usage for urine? # 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?
Supplements for bowel regularity _____
Trouble holding back gas?
Fecal incontinence or seepage?

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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 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 _____ Painful/heavy periods?

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?

Other_____