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	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:_____
  _____

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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

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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_____