Patient Information:

Name:_____Age: _____ Phone Number:_____
Emergency Contact:_____ Phone Number_____
Are you currently working?_____ Employer _____
Job Title:_____ Next MD appt:_____
Referred By:_____ Primary Physician:_____
Height:_____ Weight:_____
What are your goals for therapy? _____

Medical History: please check if you have ever had problems with the following:

□Anemia	□ Depression/ Mental Health	□ Headaches/ Migraines	□ Memory	□ Seizures
□ Arthritis	□ Diabetes	□ Hearing	□ MRSA	□ Serious accident
□ Back trouble	□ Drinking or drugs	□ Heart	□ Muscle	□ Sinus/allergies
□ Balance	□ Ear, nose, throat, mouth	□ HIV/AIDS	□ Neuropathy	□ Skin
□ Bleeding	□ Fainting	□ Infection, recent	□ Night Sweats, recent	□ Speech
□ Blood clots	□ Falls	□ Intestinal	□ Open wound	□ Spinal stenosis
□ Blood pressure	□ Fever, recent	□ Joint(s)	□ Osteoporosis	□ Stomach Ulcers
□ Blood transfusion	□ Fractures	□ Kidney	□ Pancreatitis	□ Stroke
□ Bowel/Bladder (recent changes)	□ Gallstones	□ Liver	□ Prostate	□ Swallowing
□ Brain injury	□ Gynecologic	□ Low energy level	□ Numbness in/around the genitals	□ Thyroid
□ Cancer_____		□ Lung /breathing		□ Vision
				□ Weight change, (unexplained)

Other, please specify:_____

Do you have a pacemaker or implanted stimulator?_____
Do you: □ Smoke □ Drink Alcohol, Drinks per week? □1-3 □ 4-6 □ 7-9 □ 10-12 □ 13-15 □16+
Surgeries/Hospitalizations: (Please list type of surgery and date)_____
_____
Has your doctor given you any restrictions? _____
List current medications: _____
_____
List allergies (Food/medication)_____ Latex/Rubber sensitivity □ Yes □ No_____
If you have pain: Circle the number which best describes the intensity of your pain
Highest Pain level: (best) 0 1 2 3 4 5 6 7 8 9 10 (worst)
Lowest Pain level: (best) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Functional Status: Your therapist will need the following information to support the need for skilled therapy.

Please check all areas where you are now having more difficulty due to your present injury/illness:

□ Sleeping	□ Cooking	□ Sit to stand	□ Paying attention	□ Managing medications
□ Sexual Intimacy	□ Cleaning	□ Standing	□ Reading	□ Managing schedule
□ Swallowing	□ Laundry	□ Walking	□ Paying bills	□ Computer/phone use
□ Talking	□ Driving	□ Climbing stairs	□ Writing	□ Other:(specify)
□ Bathing	□ Grocery shopping	□ Lifting	□ Remembering	
□ Dressing	□ Caregiving	□ Working	□ Understanding	
□ Grooming	□ Lawn care/gardening	□ Recreation/hobbies		

Carolinas Healthcare System
Pelvic Rehabilitation Intake Form

Facility_____

#5111 10/16/08 *616*

Patient Identifier

Patient Name

U/MR#

Physician

Social History:

Living Situation: □ Alone □ With family □ With friends □ Other_____

Do you have difficulty getting in and out of your house by yourself? □ Yes □ No

Have you ever been afraid of, hurt, or forced by anyone against your will, or been a victim of sexual abuse? □ Yes □ No

During the past year have you often been bothered by feeling down, depressed or hopeless? □ Yes □ No

During the past month have you often been bothered by little interest or pleasure in doing things? □ Yes □ No

Are you having difficulty driving? □ Yes □ No

Is transportation a problem? □ Yes □ No

Do you have unmet needs for basic food, shelter and medication? □ Yes □ No

Have you had major life changes or events that may impact your therapy? □ Yes □ No

Are you currently using any medical equipment? □ Yes □ No

Describe_____

Have you fallen in the past year? □ Yes □ No

If yes: How many times have you fallen? _____

Did you injure yourself when you fell? □ Yes □ No

Please describe any injury from falling:_____

How, when and where did you fall? _____

Has your job recently changed? □ Yes □ No

Occupation_____

Which hand do you write with? □ Left Hand □ Right Hand

Do you currently have a nurse/home health aide coming to your home? □ No □ Yes

Bladder History :

Average fluid intake per day: # 8 oz cups _____, # of which are caffeinated _____

Average voids per day: during awake hours _____, during night_____

Do you ever have: □ An uncomfortably strong urge to pass urine □ Difficulty initiating urine stream

□ A slow, interrupted or dribbling stream □ Difficulty emptying bladder completely

□ Difficulty delaying voiding, or "holding it"

□ Leakage of urine ; how much urine? (small, medium, large amounts) _____

How many times/day_____ What time of day? _____

With what activities? _____

Do you use protection/pads? _____How often do you change them? _____

Bowel History

Average frequency of bowel movements _____

Do you have: □ Difficulty delaying bowel movements □Constipation □ Diarrhea □ Hemorrhoids

□ Leakage of stool, how often? _____ how much? (small, medium, large amounts) _____

OB GYN history (if applicable)

Are you: □ Having regular periods; any problems? _____

Average length of menstrual cycle_____

□ Sexually active any problems? _____

Have you been pregnant? □ Yes □ No if yes - how many times _____How many vaginal deliveries _____

How many c-sections _____ Did you have episiotomy_____ perineal tearing _____

Do you have: □ A feeling of "falling out" □ Recurrent yeast infections

At the present time would you say your overall health is: □ **Excellent** □ **Very Good** □ **Fair** □ **Poor**

_____Below this line for clinician use only_____

Follow-Up Recommendations: □ Social Work Assessment □ Nutrition Consult □ Balance Assessment

This intake form was reviewed by:_____ Date_____

Clinician Signature

Patient Name

U/MR#

Physician