juliewiebept
CLINICIAN/EDUCATOR

Patient Intake Form

Name: _____ Date: _____

Address: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Physician Name: _____ Phone: _____

Reasons for Seeking Help: _____

(What activities are you avoiding due to pain, discomfort, weakness, leaking or urge to urinate?) _____

_____

_____

_____

Number of Pregnancies: _____ Ages of Children: _____

Pregnancy Complications: _____

_____

_____

Delivery Type(s):(V/C/VBAC): _____

Delivery Complications: _____

_____

_____

Nursing (Now or Then): _____

Fitness (Current): _____

Fitness During Pregnancy: _____

Fitness Between Pregnancies: _____

Fitness Goals: _____

Patient Intake Form (...continued)

Aches and Pains? (Now): _____

_____

Aches and Pains? (During Pregnancy) : _____

_____

Unwanted Leaking of Urine?:_____

Urgency to urinate? Change in Frequency? (Currently or During Pregnancy) _____

_____

_____

_____

GYNE Issues?: _____

Prolapse, Pain with Sex, Pain with Tampon, Tampon retention? _____

_____

_____

_____

Diastasis? (Yes/No, width):_____

_____

_____

_____

Any Dizziness, Vertigo? : _____

_____

_____

_____

GI Issues?: _____

(Constipation or GERD) _____

_____

_____

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Patient Intake Form (...continued)

Respiratory Issues?: _____

_____

_____

_____

Any other limitations?: _____

Lifting, Stairs, Driving, Prolonged Standing, Fitness? _____

_____

_____

Goals?: _____

_____

_____

_____

Past Medical : _____

Surgeries, Injuries, Breathing Issues? _____

_____

_____

Anything else you want to share? : _____

_____

_____

_____

_____

_____

_____

_____

_____

_____