New Client Intake Form

Today's date: ______________________________

Name: ___________________________________ Preferred name: __________________
Date of birth: ___________________
Email address: ____
Phone/Mobile number: __________________________________
Home address: ____
Emergency contact name: _____________________________ Phone: __________________

Primary Care Physician (PCP)/OBGYN/UroGyn: _____________________________________
Phone: _______________________________________ Fax: __________________________

Primary Concern/Symptoms:
____
____
When did symptoms begin?: ______________________________
What are your goals for physical therapy treatment: __________________________________

Pertinent Past Medical History including surgeries (i.e., hysterectomy, gallbladder, laparoscopies, diabetes, asthma, arthritis, etc): _______________________________________

____
____
Current medications: ____
Allergies: ____

History of abuse: Yes No Sexual abuse? Physical abuse? Verbal abuse?
If yes, are you currently attending mental health counseling: ________

Gynecologic History
Are you sexual active?________ If yes, is it painful? ___________________
Have you ever been pregnant, if yes, how many pregnancies?: _________
Are you currently pregnant? __________
Vaginal births: _________ Cesareans: __________ Miscarriages/Terminations: _________
Complications with pregnancy/delivery: ____
Are you currently undergoing hormone/fertility treatment?________
If yes, with which practice/treatment group: ______________________
History of perinatal and/or postpartum depression/anxiety: __________
If yes, are you currently attending mental health counseling: ____________

Urinary Symptoms(check boxes option/write your own options)
Do you experience urinary incontinence (urinary leakage) with any of the following:

- Leaks with urgency
- Leaks on route to restroom
- Leaks with physical activity/jumping
- Leaks with bending/lifting
- Leaks with cough or sneeze
- Leaks after you are done using restroom/pulling up underwear
- Leaks at night
- Leaks for no reason at all

How often are you using the restroom (to empty bladder) during the day (ex: every 2 hrs): ____
How often are you getting up to use the restroom at night: ______
Do you feel you completely empty your bladder after voiding? _____
Do you have pain before, during or after emptying your bladder? _____
Are you using pads or liners to manage any urinary leakage? If Yes, how many? ______
How much water do you drink in a day: ______ (ounces/cups option?)
What other beverages do you consume: ___________________________

Bowel Symptoms (check boxes option/write your own options)
How often do you have a bowel movement? ___/day and/or ____/week
Is your stool easy to pass?_____
If you had to describe your stool, what would it look like? _____________________________

Do you have to strain or apply pressure at your perineum to fully evacuate your bowels? _Y/N_
Once you have finished your bowel movement do you feel completely empty? ___________
Are you taking any medications or laxatives/stool softeners to have a bowel movement? Y/N_
If yes, which ones: ____
Do you lose stool unintentionally with passing gas?_Y/N_
Do you notice smearing feces/stool in your underwear/liner? _Y/N__

Orthopedic Symptoms
Are you physically active? List activities (ex; running, Peloton, HIIT, low impact aerobics):
____
____
Describe pain: (ex: knee, hip, wrist, ankle): ____
____
Pain scale (0-10) Current: _____/10 Worst: _____/10 Best: _____/10
Activities that worsen pain: ____
Activities that relieve pain: ____

Please fill in PDF with your answers and email the PDF
to Dr Frank at: **drkelly.frank@franklypelvic.com**