New Client Intake Form

Today's date: _____

Name: _____ Preferred name: _____
Date of birth: _____

Email address: _____
Phone/Mobile number: _____
Home address: _____
Emergency contact name: _____ Phone: _____

If you were referred, who referred you?: _____
Medical/Care Provider: _____
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/supplements: _____
Allergies: _____

History of abuse: ____ Sexual____ Physical ____ Verbal____ Emotional_____
If yes, are you currently attending mental health counseling: _____

Do you have a history of bedwetting?: _____ If yes, until what age: _____
Did you have a history of constipation as a child?"_____
Did your parents alleviate that with medication or supplement

regimen?:_____ If yes, what medication (i.e., Miralax, suppositories, etc):
_____

Do you have a history of hernias (umbilical, inguinal, etc):_____
Did you have any surgeries to correct them?:_____

(Vulva/Vagina owners) History

Do you have a history of cancer? (list all cancers): _____
Are you sexually active?_____ If yes, is it painful? _____
Pain with initial penetration? _____ Deeper thrust? _____ Orgasm? _____
Have you ever been pregnant, if yes, how many pregnancies?: _____
Are you currently pregnant? _____ ; If Yes, how many weeks: _____
(If applicable, check all that apply)
Are you currently: Breastfeeding _____ Pumping _____ Formula _____
Vaginal births: _____ Cesareans: _____ Miscarriages/Terminations: _____
Complications with pregnancy/delivery: _____
History of perinatal and/or postpartum depression/anxiety: _____
If yes, are you currently attending mental health counseling: _____
Do you feel heaviness or pelvic pressure? _____
Do you experience vaginal dryness?: _____ Itchiness?:_____
Are you currently undergoing hormone or fertility treatment?_____
If yes, with which practice/treatment group: _____
Do you still have a menstrual cycle?:_____If no, date of last menstrual cycle: _____
Do you or did you experience painful periods?:_____
How long do you bleed when menstruating (# of days, include spotting):_____

(Penis owners) History

Do you have urinary hesitancy? _____
Do you leak/dribble on the way to the restroom? _____
Leak/dribble when you are done using the restroom?_____
Do you wipe excessively (after bowel movement)?:_____
Do you have a history of cancer? _____: If Yes, what/which: _____
Pain with urination? _____Pain with erection? _____ Pain with orgasm? _____
Difficulty obtaining an erection?: _____ Difficulty maintaining an erection?:_____

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
- Other _____

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? _Y/N__
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? ____
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? ____
If yes, which ones: _____
Do you lose stool unintentionally with passing gas?_____
Do you notice smearing feces/stool in your underwear/liner? _____
Do you wipe excessively?:_____
How long do you sit to have a complete bowel movement?:_____

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: _____

Are there any beliefs, traditions, or customs that are important to you or your family that your therapist should know before and while treating you? If so, please list below or take a moment during our in-person intake to discuss to ensure we are treating you with the utmost care and respect you and your family deserve. Thank you.
_____
_____

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