Patient Intake Questionnaire: Prenatal and Postpartum

Name: _____ Age: _____ DOB: _____

Referring Physician: _____

Have you received previous Physical Therapy for this problem? ☐ Yes ☐ No
Have you received other treatment for this problem? ☐ Yes ☐ No If yes, what type of treatment have you received (medication, chiropractor, etc.)?

_____
_____

Medical History (Please **circle** all that apply):

Heart Problems	Hypertension	Diabetes
Hypoglycemia	Cancer	Seizures
Thyroid Dysfunction	Hx of fractures	Asthma
Chronic bronchitis	Lung Disease	Smoker
Osteoarthritis	History of Stroke	Rheumatoid Arthritis
Kidney Problems	Depression	Preeclampsia
Osteoporosis	DVT	

Other: _____

Please list all surgeries and their dates:

_____
_____

Current Medications:

_____
_____
_____

Allergies:

_____
_____

Gynecological History (Please fill in the blanks for all that apply.)

Number of Pregnancies: ____ Number of Miscarriages: ____ Number of Vaginal Deliveries:____

Number Episiotomies: ___ Number Vacuum/Forceps deliveries: _____ Number C-sections:_____

Birthdates and weight of each baby:

Birthdate	Weight in pounds	Birthdate	Weight in pounds

Any problem (physical or other) after deliveries?

_____

_____

_____

Any history of or currently have (**check all that apply**): Feelings of pelvic heaviness: _____ Cysts: _____
Fibroids: _____ Endometriosis: _____

Status (check by statement that applies and answer related questions)

☐ **I am currently pregnant:** I am at _____ weeks gestations, with the due date of _____

Have you had any concerns during this pregnancy? ☐ Yes ☐ No

If yes, please specify: _____

Has your physician placed you on any restrictions? ☐ Yes ☐ No

If yes, please specify: _____

Have you experienced any problems during previous pregnancies? ☐ Yes ☐ No

If yes, please specify: _____

☐ **I have had my baby already:** I am ____weeks post-partum and delivered on:_____

Type of delivery: ☐ Vaginal ☐ Forceps ☐ Vacuum ☐ Episiotomy ☐ Perineal tear ☐C-section

If C-section, was it planned? ☐Yes ☐No If no, did you labor prior to the C-section? ☐Yes ☐No

If you had a perineal tear, so you know what grade tear? ☐ Yes ☐ No

If yes, what grade tear? _____

Did you experience any problems during this pregnancy? ☐ Yes ☐ No

If yes, please specify: _____

Are you experiencing any problems at the site of the C-section, episiotomy or perineal tear? ☐ Yes ☐ No

If yes, please specify: _____

☐ **I recently experienced a miscarriage.** Date of miscarriage: _____

Bowel / Bladder Symptoms:

Are you experiencing any problems with urinating or leaking urine? ☐ Yes ☐ No

Are you experiencing any problems with bowel or leaking feces or gas? ☐ Yes ☐ No

Current Symptoms:
What brings you in for therapy today?

_____
_____

Do you have pain? ☐ Yes ☐ No If yes, where is your pain:

_____
_____

Describe how the pain feels
When did the pain first begin? _____
Are any of your normal activities limited by pain? ☐ Yes ☐ No If yes, please specify:

_____
_____
_____

What makes your pain worse? _____

What makes your pain feel better? _____

Rate your pain on the following scale:
0 = no pain at all 5 = moderate pain 10 = worst pain imaginable

At the **worst** your pain is (circle one):
0 1 2 3 4 5 6 7 8 9 10

On **Average** your pain is (circle one):
0 1 2 3 4 5 6 7 8 9 10

Is there any other information you would like to share about your symptoms?_____
_____

Work Status (Please **CHECK** all that applies): ☐ Currently Working ☐ On Maternity Leave ☐ Not Employed
Other:

Type of Work: _____
How many hours at work: _____

Fill out this section ONLY if you have given girth in the last 12 weeks.
Answer the following 3 questions by placing a check mark next to your response:

In the LAST 7 DAYS:

I have blamed myself if unnecessarily when things went wrong.
☐ Yes, all the time ☐ Yes, most of the time ☐ No, not very often ☐ No, not at all

I have felt panicky or scared for no very good reason.
☐ Yes, all the time ☐ Yes, most of the time ☐ No, not very often ☐ No, not at all

I have been anxious or worried for no good reason.
☐ Yes, all the time ☐ Yes, most of the time ☐ No, not very often ☐ No, not at all