REHAB MEDICINE at
GRANDVIEW/SOUTHVIEW
MEDICAL CENTERS
KETTERING HEALTH NETWORK

Patient Intake Form

Name:_____ Date:_____

Pain

1. Do you have pain? ☐ Yes ☐ No
2. Please rate your pain from 0 – 10 (0 is no pain and 10 is the worst pain): _____
3. Where is your pain: _____

OB/GYN History

1. Date of last menstrual period: _____
2. Do you have regular periods? ☐ Yes ☐ No
3. Are you breastfeeding? ☐ Yes ☐ No
4. Please indicate the number of pregnancies you have had: _____
5. Please indicate the number of Vaginal deliveries you have had: _____
6. Please indicate the number of Cesarean deliveries you have had: _____
7. Have you ever had an episiotomy? ☐ Yes ☐ No
8. Have you ever been diagnosed with: ☐ Cystocele ☐ Uterus Prolapse ☐ Rectocele
9. Have you ever been a victim of sexual abuse? ☐ Yes ☐ No

Allergies:

Please list any allergies: _____
_____

Medications:

Please list current medications:

Name:	Dosage:	Reason for Taking:

Past Medical History

1. Please check any of the conditions that you have been treated for or have been diagnosed with:

☐ Asthma	☐ Depression	☐ Myocardial Infarction
☐ Anemia	☐ Diabetes Mellitus	☐ Nerve/Muscle Damage
☐ Anxiety	☐ Emphysema	☐ Osteoporosis
☐ Arthritis	☐ GERD	☐ Seizures
☐ Glaucoma	☐ Sickle Cell Anemia	☐ Blood Transfusion
☐ Heart Murmur	☐ Stroke	☐ Cancer
☐ HIV/AIDS	☐ Substance Abuse	☐ Cataracts
☐ Hypertension	☐ Thyroid Disease	☐ Congestive Heart Failure
☐ Kidney Disease	☐ Tuberculosis	☐ Clotting Disorder
☐ Meningitis	☐ Ulcers	☐ COPD

☐ Other:_____

2. Please list any surgeries you have had:

_____

_____

_____

Hysterectomy? ☐ Yes (Date:_____) ☐ No

Bladder suspension? ☐ Yes (Date:_____) ☐ No

Social History:

1. Do you use any of the following: ☐ Cane ☐ Walker ☐ Wheelchair

2. How many hours do you sleep at night? _____

3. Is your sleep interrupted? ☐ Yes ☐ No

Incontinence History

1. Have you ever seen a doctor for an incontinence problem? ☐ Yes ☐ No
   What did the doctor do?_____

2. Do you experience urinary leakage during any of the following?

☐ Cold	☐ Continuous Leaking	☐ Coughing
☐ Dribble after urination	☐ Exercise	☐ Key in the door
☐ Laughing	☐ Lifting	☐ Nervousness
☐ On way to the restroom	☐ Position Changes	☐ Running water
☐ Rushing	☐ Sleeping	☐ Sneezing
☐ Walking	☐ Without being aware	☐ Other: _____

3. How often do you leak during a typical week?
   ☐ Less than once a week ☐ More than once a week ☐ Once a day
   ☐ More than once a day ☐ Other: _____

4. When does the leakage occur?
   ☐ During the day ☐ At night ☐ Day and night

5. When you leak, how much do you leak?
   ☐ Damp/A few drops ☐ Wets underpants ☐ Quite wet/A cupful

6. How often do you urinate during the day:
   ☐ More than every hour ☐ Every 1-2 hrs ☐ Every 3-5 hrs ☐ Frequency varies
   ☐ Other: _____

7. Do you wake up at night to urinate:
   ☐ Never or rarely ☐ About 1-2 times ☐ 3 or more times

8. When your bladder feels full, how long can you hold your urine?
   ☐ Less than a few minutes ☐ Just a few minutes ☐ More than a few minutes
   ☐ Cannot tell if bladder is full

Incontinence History

9. Do you have trouble getting to the toilet on time? ☐ Yes ☐ No

10. When urinating, do you experience:

☐ Bladder not fully emptying	☐ Burning	☐ Difficulty starting stream
☐ Difficulty stopping stream	☐ Discomfort	☐ Dribbling
☐ Blood in the urine	☐ Pain	☐ Post-void dribbling
☐ Weak or slow stream	☐ None	

11. Do you use any of the below for protection during urinary leaking? (check all that apply.)

☐ Bedside commode	☐ Bed or furniture pad	☐ Adult briefs/Diapers
☐ Disposable undergarment	☐ Guard for men	☐ Minipad
☐ Pantyliner	☐ Poise type	☐ Sanitary napkin
☐ None	☐ Other: _____	

12. How many times per day do you need to change pads or other products?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

13. Indicate what amount you drink of the following in a typical day:

_____ Water (ounces)	_____ Juice (ounces)	_____ Soda (ounces)
_____ Sports Drink (ounces)	_____ Coffee (ounces)	_____ Tea (ounces)
_____ Beer (ounces)	_____ Wine (ounces)	_____ Spirits (ounces)
_____ Milk (ounces)	_____ Other: _____	

14. Do you smoke? ☐ Yes ☐ No

Comments:

_____

_____

_____

_____

Bowel History

1. Do you experience any of the following?
   - ☐ Blood in the stool
   - ☐ Changes in bowel habits in the last year
   - ☐ Constipation
   - ☐ Diarrhea
   - ☐ Incontinence of bowels
   - ☐ Irritable bowel diagnosis
   - ☐ Pain with bowel movements
   - ☐ Urgency with bowels
   - ☐ Other: _____

2. Do you experience flatulence?
   - ☐ Multiple times a day
   - ☐ Once daily
   - ☐ 2-3 times weekly
   - ☐ Other: _____

3. What best describes your stool consistency?
   - ☐ Firm
   - ☐ Liquid
   - ☐ Pellet
   - ☐ Soft

4. How often do you have a bowel movement?
   - ☐ Once daily
   - ☐ 2-3 times daily
   - ☐ 1-2 times weekly
   - ☐ Less than 1 time weekly
   - ☐ Laxative use
   - ☐ Other: _____

Pain History

1. Do you have any complaints of: (check all that apply)
   - ☐ Vaginal burning
   - ☐ Vaginal dryness
   - ☐ Vaginal itching
   - ☐ Vaginal Sensitivity
   - ☐ Other vaginal symptoms

2. Do you have pain with intercourse? ☐ Yes ☐ No

3. Do you experience urinary leaking with intercourse? ☐ Yes ☐ No

Patient Signature:_____ Date:_____

Therapist Signature:_____ Date:_____