Women's Health Occupational Therapy

Leelanau Physical Therapy
5901 Shugart Lane
Traverse City, MI 49684
Call: 231.943.1655
Fax: 231.943.1656
lptwest@leelanaupt.com

Please reach out with any questions, and we look forward to meeting you.

Your Biographical Information

Demographic information:

Name: _____ Date of birth: _____ Sex: _____

Social Security Number: _____ Relationship status: _____

Mailing address: _____

How can we reach you?

Phone number: _____ OK to leave voicemail? ☐ *Yes.* ☐ *No.*

Email address: _____ OK to send you emails? ☐ *Yes.* ☐ *No.*

Who is your primary care doctor?

Name: _____ City/State: _____

Did this doctor refer you to us? ☐ *Yes.* ☐ *No.* If not, who did?: _____

Who is your emergency contact?

Name: _____ Phone number: _____ Relationship: _____

The Reason for your Appointment

What is the reason for your appointment?

_____

_____

_____

When did this problem start?

_____ months or _____ years ago

Since then, has it been: ☐ *Better.* ☐ *Worse.* ☐ *The same.*

Does it affect your ability to:

Work or study? ☐ *Yes.* ☐ *No.*
Enjoy your hobbies? ☐ *Yes.* ☐ *No.*
Exercise? ☐ *Yes.* ☐ *No.*
Care for yourself? ☐ *Yes.* ☐ *No.*
Enjoy your relationships? ☐ *Yes.* ☐ *No.*
Sleep? ☐ *Yes.* ☐ *No.*

Describe your symptoms:
☐ constant, ☐ intermittent, ☐ infrequent, ☐ random, ☐ aching, ☐ stabbing, ☐ burning, ☐ worse at night, ☐ worse with activity, ☐ worse with rest, ☐ better in the morning, ☐ cramping, ☐ tearing sensation, ☐ dull, ☐ other, explain:

How severe is your pain?

Have you seen other providers or received other treatment for this problem? *What helped? What didn't?*

Are you aware of a specific incident or accident that caused your pain?

What causes or worsens your pain?
☐ having my period | ☐ using pads or pantiliners | ☐ inserting tampon
☐ sitting {If so, how long can you sit without pain?: _____ minutes}
☐ walking {If so, how long can you walk without pain?: _____ minutes}
☐ standing {If so, how long can you stand without pain?: _____ minutes}
☐ sitting on hard surfaces | ☐ sitting in the car | ☐ driving | ☐ sitting on the toilet
☐ sex | ☐ masturbation | ☐ sexual arousal
☐ tight clothing | ☐ underwear | ☐ clothing seams
☐ feeling anxious or stressed | ☐ being sleep-deprived
☐ lifting {children, groceries, weights} | ☐ bending | ☐ jumping | ☐ jogging
☐ sneezing | ☐ constipation | ☐ urination | ☐ using vaginal dilators
☐ other triggers:

What makes your pain better?
☐ pain medications | ☐ rest | ☐ movement {If so, what type?: _____}
☐ other:

Activity & Lifestyle Information

How do you spend your time?

If you didn't have this problem, how would you spend your time?

Your exercise habits:
Do you exercise? ☐ *Yes.* ☐ *No.* If so, what kind? _____ How many days per week? _____
Do you have a fitness club membership? ☐ *Yes.* ☐ *No.* If so, where? _____

Your relaxation habits:
What do you do to relax?

Do you use: ☐ alcohol, ☐ marijuana, ☐ prescription sleeping pills, ☐ homeopathic sleep remedies

Your social habits:

Describe your social life:

How has this condition affected your social activities and friendships?

Your lifestyle habits:

Hours you sleep each night: _____

Do you feel rested in the morning? ☐ *Yes.* ☐ *No.* Do you get up during the night? ☐ *Yes.* ☐ *No.*

What is your nighttime routine? _____

What time do you eat dinner? _____

Do you have a special diet? ☐ *Yes.* ☐ *No.* If so, describe:

Where do you get most of your meals? ☐ *I cook.* ☐ *I dine out.* ☐ *Other:*

Do you have food allergies? ☐ *Yes.* ☐ *No.* If so, describe:

Do you have skin allergies? ☐ *Yes.* ☐ *No.* If so, describe:

Wellness habits & activities: *(This information will help us set recovery goals and assess your progress.)*

☐ Receive regular massages.	☐ Currently breastfeeding.	☐ Receive energy therapy.
☐ Participate in wellness retreats.	☐ Walk your dog.	☐ Travel.
☐ Walk or bike for your commute.	☐ Drive your car.	☐ Meditate.
☐ Play with or care for children.	☐ Have regular sex.	☐ Note of these things.

Helpful Health Information

Do you feel like you're in generally good health? *Please discuss.*

Do you get regular physicals? ☐ *Yes.* ☐ *No.* Did you get a flu shot this year? ☐ *Yes.* ☐ *No.*

Do you get regular pelvic exams? ☐ *Yes.* ☐ *No.* Date of last urinalysis _____ and bloodwork _____.

What medications do you take? *You can also just bring a pre-printed list.*

Name of medication	**Reason**	**Other comments:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who do you consider your healthcare team? *Provide their names and the frequency of your visits.*

Name	Specialty / Reason for Visits	Frequency of Visits
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emotional wellness:

Do you have any mental health diagnoses you wish to share with us? _____

Do you regularly feel: ☐ anxious, ☐ depressed, ☐ sleepless, ☐ hopeless, ☐ suicidal, ☐ scared, ☐ self-harming.

Other mental health symptoms:

Do you feel safe from violence, coercion, and abuse at home? ☐ *Yes.* ☐ *No.*
If not, we can direct you to social service agencies that can assist you. It's safe to tell us.

Reproductive health (for women)

Are your periods regular? ☐ *Yes.* ☐ *No.* Date that your last period began: _____, or menopause onset: _____

Are your periods painful? ☐ *Yes.* ☐ *No.* Describe:

Are you sexually active? ☐ *Yes.* ☐ *No.* Gender of sexual partners: ☐ *Female* ☐ *Male*

Do you use contraception? ☐ *Yes.* ☐ *No.* If so, what?

Are you pregnant? ☐ *Yes.* ☐ *No.* Are you trying to become pregnant? ☐ *Yes.* ☐ *No.*

How many pregnancies have you had? How many births have you had? ___ vaginal, ___ cesarean

Have you had pregnancy or birth complications? ☐ *Yes.* ☐ *No.* If so, describe:

Which of the following do you now or have you ever experienced:

☐ painful sex, ☐ achiness or cramping with sex, ☐ painful arousal/orgasm, ☐ vaginal dryness, ☐ pelvic organ prolapse, ☐ urinary leaking, ☐ bowel dysfunction, ☐ irregular periods, ☐ lack of interest in sex, ☐ vulvar pain, ☐ internal vaginal pain, ☐ vaginal heaviness or bulging sensation, ☐ painful ovulation, ☐ ovarian cysts, ☐ vulvar skin irritation, ☐ yeast infections, ☐ urinary tract infections, ☐ itchiness, ☐ pain with tampons, ☐ clitoral pain, ☐ perineal tearing sensation, ☐ frequent constipation, ☐ stop-and-start urination or feelings of incomplete emptying, ☐ pain or irritation with clothing, ☐ episiotomy

Describe other reproductive or pelvic health history or events:

Surgical History

Have you had surgery before? ☐ *Yes.* ☐ *No.* If yes, provide date and reason for each:

Date of procedure	**Reason for procedure**
_____	_____
_____	_____
_____	_____
_____	_____

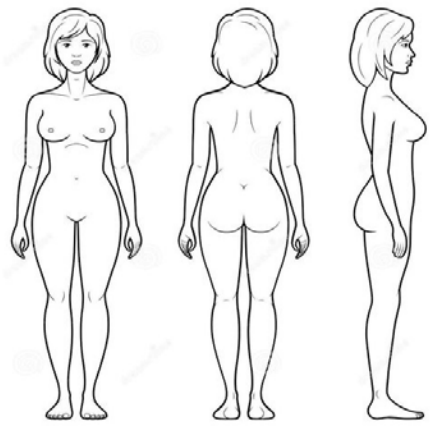
Health History

Do you now or have you ever had:

☐ Asthma
☐ Emphysema, COPD
☐ Heartburn
☐ Heart disease
☐ Pacemaker or defibrillator
☐ High blood pressure
☐ Heart attack or heart surgery
☐ Blot clot, emboli
☐ Stroke, TIA
☐ Allergies*
☐ Latex allergy or sensitivity
☐ Osteoporosis
☐ Pin/metal implants*
☐ Joint replacement*
☐ Diabetes
☐ Infectious diseases*
☐ Cancer
☐ Chemotherapy/radiation*
☐ Arthritis, swollen joints
☐ Sleep problems
☐ Severe, frequent headaches
☐ Vision or hearing problems
☐ Numbness, tingling
☐ Dizziness, fainting
☐ Weakness
☐ Weight loss, energy loss
☐ Hernia
☐ Epilepsy, seizures
☐ Thyroid problems
☐ Incontinence
☐ Bowel, bladder problems
☐ Neck/back surgery, injury
☐ Multiple Sclerosis
☐ Parkinson's Disease

**Additional Details:*

Where do you hurt?



Signatures

I understand that Leelanau PT & my therapist will rely upon the information I provided in these forms when rendering my treatment. My answers are complete and accurate to the best of my knowledge.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date

For dependent or minor patients:

_____	_____	_____
Guardian's Printed Name	Guardian's Signature	Date

For practice use. I reviewed these forms in-person with the patient and understand the reason for presentation in the clinic. *Initial:* _____ *Date:* _____

INFORMED CONSENT FOR OCCUPATIONAL THERAPY SERVICES

You will complete this form with your provider at the first visit.

I, _____, acknowledge that Leelanau Physical Therapy and its owners, agents, or employees (the "Practice") will provide the following occupational therapy services ("OT Services").

For the Practice's use. *To be completed with patient.*

(1) *OT Services to be Rendered*:

(2) *Material Risks:*
I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing condition. This is usually temporary, I agree to contact my therapist if the discomfort does not subside within 24 hours.

(3) *Potential Material Benefits:*
I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may have decreased pain and discomfort. I may have the opportunity to gain a greater knowledge about managing my condition and the resources available to me.

(4) *Information about alternatives:*
I have the Right To Refuse any of the evaluation, examination, and/or treatment techniques, at any time. If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

I further acknowledge that:

- ✓ These OT Services and their material risks and benefits have been explained to me;
- ✓ These OT Services may not have the result that I expect, and I have been informed as to other possible services that may provide me a benefit;
- ✓ OT Services are not an exact science, and that I have not been given any guarantees about the result;
- ✓ I have had ample opportunity and time to discuss my concerns with the Practice or any healthcare provider, and all my questions have been answered to my satisfaction; and
- ✓ By signing below, I hereby provide my informed consent to receive OT Services as described above.

_____ _____

Signature Date