PATIENT QUESTIONNAIRE: PRENATAL & POSTPARTUM

Name: ______________________________ **Age:** _____ **DOB:** ______________

Referring Doctor: ______________________ **Diagnosis:** ____________________________________

Have you received previous Physical Therapy for this problem? (circle) No OR Yes: (date):__________

Have you received other treatment for this problem? No OR Yes: (type)__________________________

Medical History (circle all that apply): heart problems / hypertension / diabetes / cancer / seizures
thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis
rheumatoid arthritis / hx of stroke / kidney problems / depression / preeclampsia / osteoporosis / DVTs
Other:____

Surgical History (list type & date): ____

____

Gynecological History (fill in blanks or circle answer for all that apply): Number miscarriages_______
Number of pregnancies______. Number of vaginal deliveries________. Number of C-sections________
Number of episiotomies______. Number of vacuum/forceps assisted deliveries __________.
Birthdates & weight of each baby: ____
Any physical problems after previous deliveries? ____

____

Any active infections at this time? No OR Yes: (specify type/treatment)_________________________
(Circle any that apply): Feelings of pelvic heaviness / history of: fibroids / cysts / endometriosis

Current Medications: ____

Allergies: ____

Work Status: ☐ currently working ☐ on maternity leave ☐ not employed ☐ other:___________

Location / type of work: ____

Emergency Contact:
Name: ______________________________________ Daytime phone #: (____)________ -__________

How did you learn about us? ☐ friend ☐ physician ☐ internet ☐ advertisement ☐ other:

Date of your next doctor's appointment: ___________________________

______________________________   _______________________
Patient's Signature   **Date**

PERINATAL: SYMPTOM QUESTIONNAIRE

Current Status: (Check by statement that applies and answer subsequent questions.)

___ **I am currently pregnant.**

I am at _____ weeks gestation, with the due date of ______________ .

Have you had any concerns during this pregnancy? No OR Yes (please specify below)

____

Has your physician placed you on any restrictions? No OR Yes (please specify below)

____

Have you experienced any problems during previous pregnancies? No OR Yes (specify)

____

___ **I am post-partum.**

I am ____ weeks post-partum, having delivered on the date of _____________.

Type of delivery (circle all that apply): vaginal / forceps / vacuum / episiotomy / perineal tear/ C-section . If C-section, was it planned or did you labor prior to the procedure?________

If perineal tear, do you know what grade tear? ________________________

Did you experience any problems during this pregnancy? No OR Yes (please specify):

____

Are you experiencing problems at the site of C-section, episiotomy or perineal tear? No OR Yes (specify): ____

___ **I recently experienced a miscarriage.**

Date of miscarriage: ______________

Any other information: ____

Bowel / Bladder Symptoms: (Answer "yes" or "no." If "yes," describe the problem.)

Are you experiencing any problems with urinating or leaking urine? ________________________________

____

Are you experiencing any problems with bowel movements or leaking feces? ________________________

____

Current Symptoms:

What brings you in for therapy today? ____

Do you have pain? No OR Yes: location:____

Describe how the pain feels: ____

When did pain first begin: ____

Are any of your normal activities limited by pain? No OR Yes: (specify)___________________________

____

What makes your pain worse?:____

Better?: ____

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

At worst (circle one): 0 1 2 3 4 5 6 7 8 9 10 On average: 0 1 2 3 4 5 6 7 8 9 10

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

____

____

What do you hope to achieve through therapy: ____

____

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