Core Wellness Program
Rehabilitation Screening/Confidential Medical History

THE Portland Clinic

PHYSICAL THERAPY DEPARTMENT



The Portland Clinic - South
6640 SW Redwood Ln.
Portland, OR 97224
503.620.7358 x2910

The Portland Clinic - Tigard
9250 SW Hall Blvd.
Tigard, OR 97223
503.293.0161 x4028

Patient's Name _____ Age _____ Date_____

Please complete the following questions to the best of your ability.
This will help us to develop a treatment with you that meets your individual needs.

1. What is the reason for you visiting physical therapy?_____

2. What are your goals for therapy? _____

3. When did your symptoms begin? _____

4. Are you currently being seen by any of the following? ☐ Chiropractor ☐ Osteopath ☐ Physical Therapist
   ☐ Occupational Therapist ☐ Psychiatrist/Psychologist
   If you are seeing any of the above, please describe the reason _____

5. Have you had physical/speech/occupational therapy since January of this year? ☐ Yes ☐ No
   If you answered yes, where? _____

6. Are you presently working? ☐ Yes ☐ No Occupation? _____
   If working, is it ☐ Light/Modified Duty ☐ Regular Duty How many hours per week do you work?_____

7. Do you use a ☐ Cane ☐ Walker ☐ None ☐ Other _____

8. What type of exercise are you currently doing? _____

9. Have you ever had surgery ☐ Yes ☐ No
   If yes, which body part_____ When _____

10. Are you pregnant? ☐ Yes ☐ No

11. Your stress level of past 4 weeks – circle one No Stress 0 1 2 3 4 5 6 7 8 9 10 High Stress
    Your anxiety level of past 4 weeks – circle one No Anxiety 0 1 2 3 4 5 6 7 8 9 10 High Anxiety

12. Living situation: ☐ Alone ☐ With other ☐ With assistance
    ☐ 1-story ☐ 2-story

13. Do you have a latex allergy? ☐ Yes ☐ No

14. List all medications you are taking for this problem.

_____

_____

_____

_____

_____

Body Pain Chart

Are you experiencing pain due to your current accident or illness? ☐ Yes ☐ No

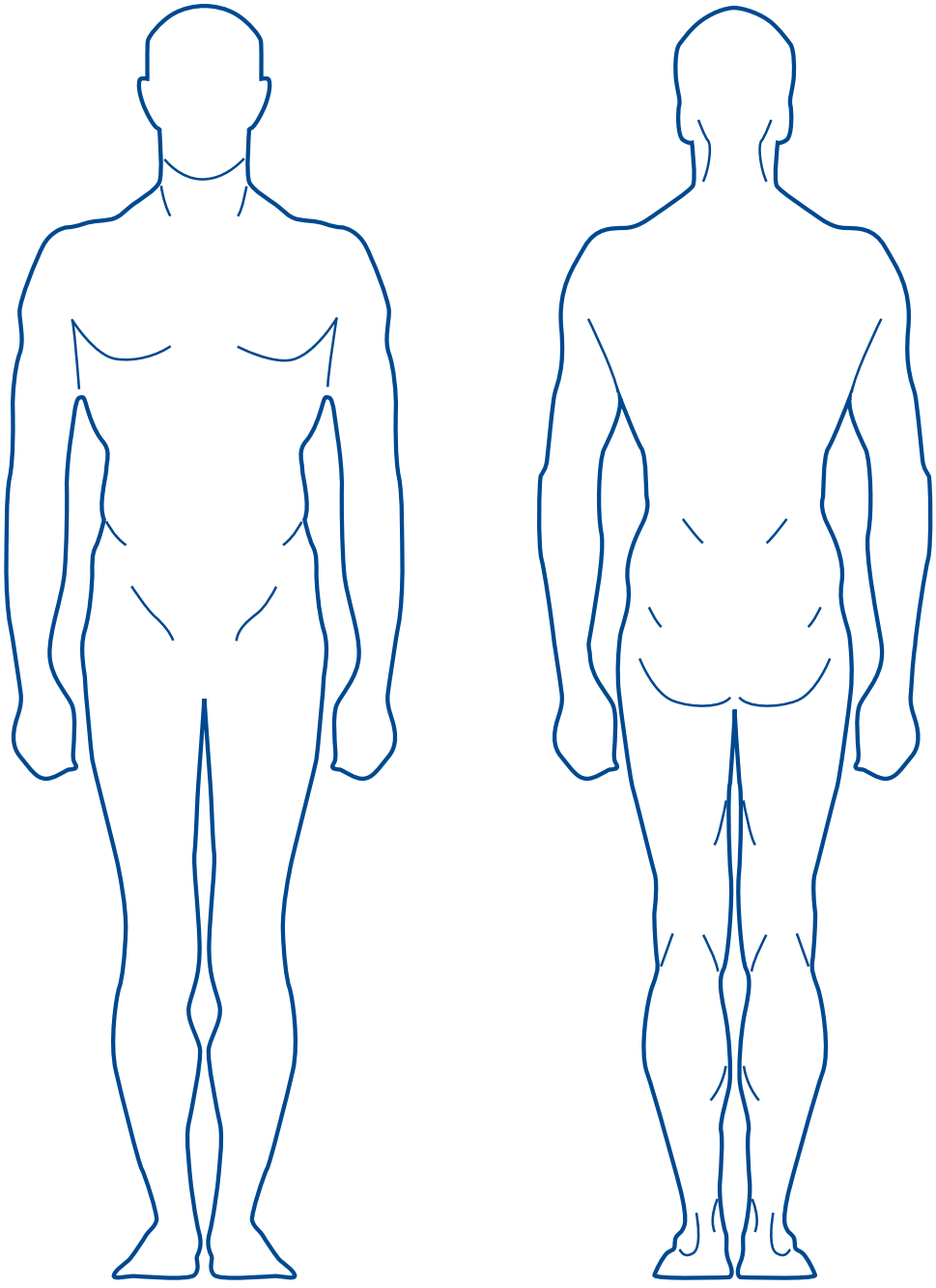
If you answered yes, indicate on the body diagrams where your pain occurs using the follow key:

/// Stabbing

XXX Burning

OOO Pins & Needles

= = = Numbness



Core Wellness Program
Continence Weekly Record

THE Portland Clinic

PHYSICAL THERAPY DEPARTMENT



Instructions: Insert the following symbols into the appropriate time spaces

T = toilet F = 8oz. fluid * = if drink was caffeinated B = bowel movement P = pad S = small leak L = large leak

DAY 1	
Date	
6-8am	
8-10am	
10-12pm	
12-2pm	
2-4pm	
4-6pm	
6-8pm	
8-10pm	
10-12am	
Overnight	
Pads used	
Comments:	

DAY 2	
Date	
6-8am	
8-10am	
10-12pm	
12-2pm	
2-4pm	
4-6pm	
6-8pm	
8-10pm	
10-12am	
Overnight	
Pads used	
Comments:	

DAY 3	
Date	
6-8am	
8-10am	
10-12pm	
12-2pm	
2-4pm	
4-6pm	
6-8pm	
8-10pm	
10-12am	
Overnight	
Pads used	
Comments:	

DAY 4	
Date	
6-8am	
8-10am	
10-12pm	
12-2pm	
2-4pm	
4-6pm	
6-8pm	
8-10pm	
10-12am	
Overnight	
Pads used	
Comments:	

DAY 5	
Date	
6-8am	
8-10am	
10-12pm	
12-2pm	
2-4pm	
4-6pm	
6-8pm	
8-10pm	
10-12am	
Overnight	
Pads used	
Comments:	

DAY 6	
Date	
6-8am	
8-10am	
10-12pm	
12-2pm	
2-4pm	
4-6pm	
6-8pm	
8-10pm	
10-12am	
Overnight	
Pads used	
Comments:	

DAY 7	
Date	
6-8am	
8-10am	
10-12pm	
12-2pm	
2-4pm	
4-6pm	
6-8pm	
8-10pm	
10-12am	
Overnight	
Pads used	
Comments:	

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Patient's Name _____ Age _____ Date_____

Please complete the following questions to the best of your ability.
This will help us to develop a treatment with you that meets your individual needs.

Do you have or have you had a history of the following? Explain yes responses and include dates.

Asthma	☐ Yes ☐ No	**Abdominal Pain**	☐ Yes ☐ No	**Pregnancies**	☐ Yes ☐ No # _____
Emphysema/Bronchitis	☐ Yes ☐ No	**Pelvic Pain**	☐ Yes ☐ No	**Pregnancy Complications**	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	**Painful Intercourse**	☐ Yes ☐ No	**Vaginal births**	☐ Yes ☐ No # _____
Low Back Pain	☐ Yes ☐ No	**Other** _____		**C-section births**	☐ Yes ☐ No # _____
Sexually Transmitted Disease	☐ Yes ☐ No	_____		**Contraception used**	☐ Yes ☐ No
Bladder Infections	☐ Yes ☐ No	_____		indicate type	_____

Explain the above responses _____

SYMPTOMS WITH THE FOLLOWING:	**Always**	**Sometimes**	**Never**
1. Do you have trouble making it to the toilet in time?	_____	_____	_____
2. Do you lose urine when you have a strong urge to urinate?	_____	_____	_____
3. Do you lose urine with any of the following?			
Coughing or sneezing	_____	_____	_____
Laughing	_____	_____	_____
Lifting	_____	_____	_____
Active exercise (running, etc.)	_____	_____	_____
Minimal exercise (walking, light housework)	_____	_____	_____
Sleeping	_____	_____	_____
Nervousness or increased anxiety	_____	_____	_____
Leakage unrelated to any specific cause	_____	_____	_____

Other, please explain _____

4. Is your clothing: wet a few drops _____, wet underwear _____, wet outer clothes _____, wet floor _____?
5. Do you empty your bladder frequently, before you experience the desire to pass urine just so you can stay dry? ☐ Yes ☐ No
6. Are you currently experiencing constipation or diarrhea? _____
7. When you urinate is it a strong or weak stream? _____ Does your stream fall straight? _____
8. When you urinate can you start or stop automatically? ☐ Yes ☐ No
9. Is there any odor to your urine or pain with urinating? _____

SEVERITY:

1. What position do you most often experience your symptoms in? _____
2. How many times per day do you experience your symptoms? _____
3. What is the time it takes you to urinate from the start of a stream to the end (measure in seconds) _____
4. Are you aware of leakage when it happens? ☐ Yes ☐ No

PROTECTION:

1. What type of protection/pad do you use? _____
2. How many times per day do you change your protection? _____

NUTRITION:

1. Have you made any dietary changes in the last 1 month? ☐ Yes ☐ No
   Please explain if Yes. _____
2. Have you changed your fluid consumption recently? ☐ Yes ☐ No
   Please explain if Yes. _____

Core Wellness Program
Incontinence Impact Questionnaire

THE Portland Clinic

PHYSICAL THERAPY DEPARTMENT

Patient's Name _____ Age _____ Date_____

Rate how your urinary incontinence affects you by using the following scale:

Not at all = 0 **Slightly =1** **Moderately = 2** **Greatly = 3** **Not applicable = N/A**

DAILY ACTIVITIES					
Cooking	0	1	2	3	N/A
Housekeeping	0	1	2	3	N/A
Laundry	0	1	2	3	N/A
Household repair work	0	1	2	3	N/A
Shopping	0	1	2	3	N/A
Hobbies	0	1	2	3	N/A
Physical recreation	0	1	2	3	N/A
Entertainment	0	1	2	3	N/A
Travel (under 30 min)	0	1	2	3	N/A
Travel (over 30 min)	0	1	2	3	N/A
Visits to places with unknown restrooms	0	1	2	3	N/A
Vacations	0	1	2	3	N/A
Church or temple attendance	0	1	2	3	N/A
Volunteer activity	0	1	2	3	N/A
SOCIAL INTERACTION					
Having friends visit	0	1	2	3	N/A
Visiting friends or relatives	0	1	2	3	N/A
Participating in social activities outside the home	0	1	2	3	N/A
Relationships with friends	0	1	2	3	N/A
Relationships with family	0	1	2	3	N/A
Relationship with husband or wife	0	1	2	3	N/A
Sexual relations	0	1	2	3	N/A
Way you dress	0	1	2	3	N/A
SELF-PERCEPTION					
Physical health	0	1	2	3	N/A
Mental health	0	1	2	3	N/A
Fear of odor	0	1	2	3	N/A
Fear of embarrassment	0	1	2	3	N/A

Adapted from Wyman et al. Obstet Gynecol, 70:380. 1987

Consent for Treatment: I hereby authorize the physical therapists at The Portland Clinic to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

(Patient Signature) (Date)