Core Wellness Program
Rehabilitation Screening/Confidential Medical History

THE Portland Clinic

PHYSICAL THERAPY DEPARTMENT

Portland South Office
6640 SW Redwood Ln.
Portland, OR 97224
503.620.7358 x2910

Tigard Office
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. Date of injury/illness or when problem last caused you to seek medical attention _____

3. How did your current problem begin? ☐ Lifting ☐ Twisting ☐ Falling ☐ Motor vehicle accident ☐ Unknown
   ☐ Other _____

4. Were you hospitalized for this problem? ☐ Yes ☐ No If yes, give dates _____

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

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

7. Are you presently working? ☐ Yes ☐ No Occupation? _____
   If working, is it ☐ Light/Modified Duty ☐ Regular Duty ☐ Full-time ☐ Part-time

8. Are you ☐ Right Handed ☐ Left Handed Do you use a ☐ Cane ☐ Walker ☐ None ☐ Other _____

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

10. Do you currently experience any of the following? ☐ Cardiac Problems ☐ Diabetes ☐ Hypertension
    ☐ Orthopedic Problems ☐ Rheumatoid Arthritis ☐ GI Problems ☐ Cancer ☐ Seizures ☐ Multiple Sclerosis
    ☐ Fibromyalgia ☐ Depression ☐ Drug/Alcohol Dependency ☐ CVA/Stroke ☐ Change in appetite

11. Have you ever had surgery or a broken bone or fracture? ☐ Yes ☐ No
    If yes, which body part_____ When _____

12. Do you smoke? ☐ No ☐ Yes, number of packs/day? _____ Are you pregnant? ☐ Yes ☐ No

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

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

15. List any medication allergies_____

16. List all prescription or over-the-counter medications you are taking for the problem you are being treated for today.

    _____

17. What are your goals for therapy?_____

Emergency Contact _____Phone Number_____

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:

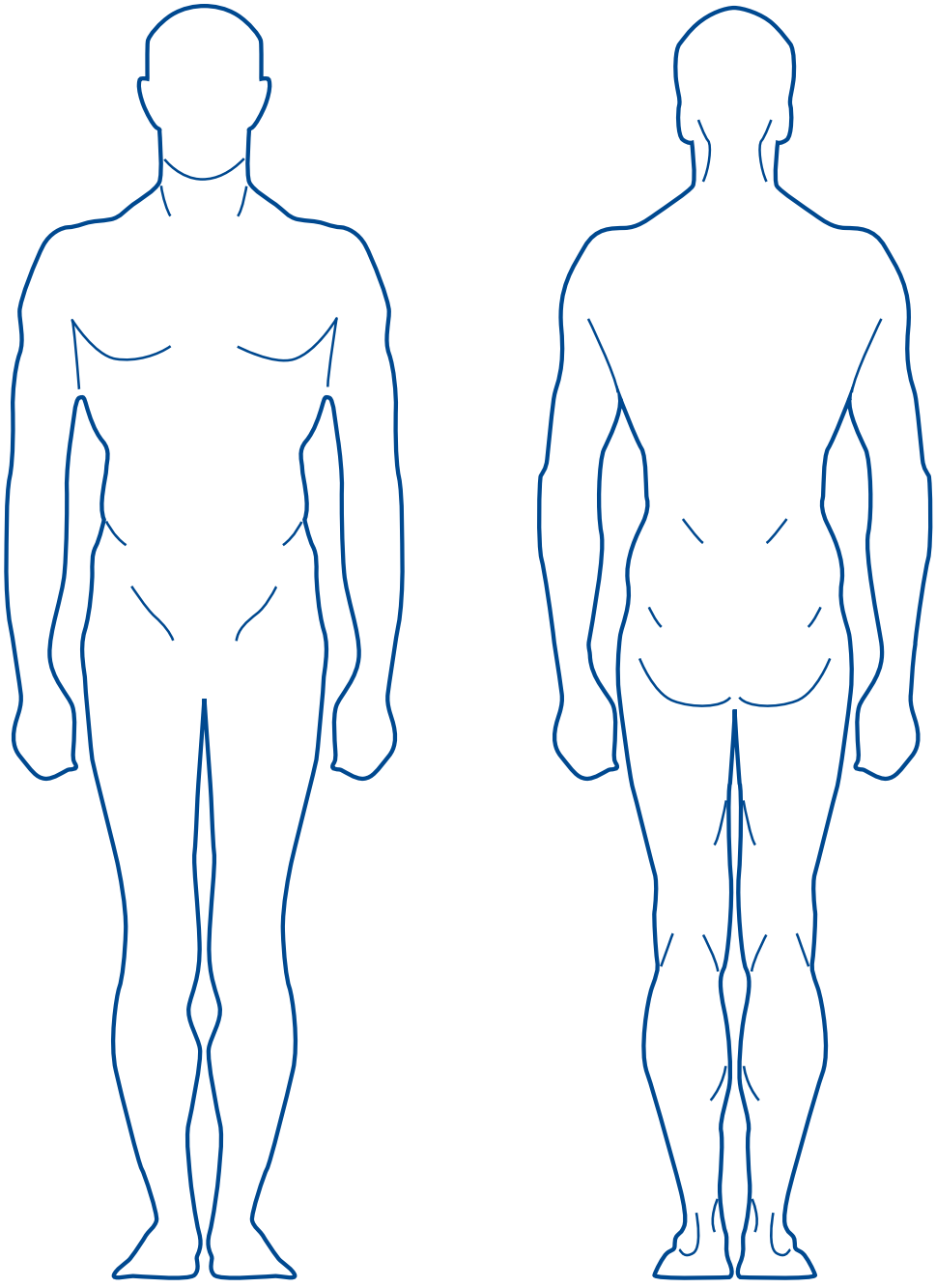
/// Stabbing

XXX Burning

OOO Pins & Needles

= = = Numbness

*** Aching



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)