Stony Brook Southampton Hospital

Department of Rehabilitation

Name: _____ **Age:** _____ **DOB**: _____ **Date:** _____

Occupation: _____ **Marital Status: S☐M☐D☐W☐**

Emergency contact info: Name: _____ Number: _____ Relationship:_____

May we speak to significant other regarding your/pt progress? Yes☐No☐

Do you have a health care proxy? Yes☐No☐Name:_____Number:_____

Allergies: List any medication (s) or food that you are allergic to: _____

Are you latex sensitive? Yes☐ No☐

Are you currently pregnant or think you may be pregnant? Yes☐No☐

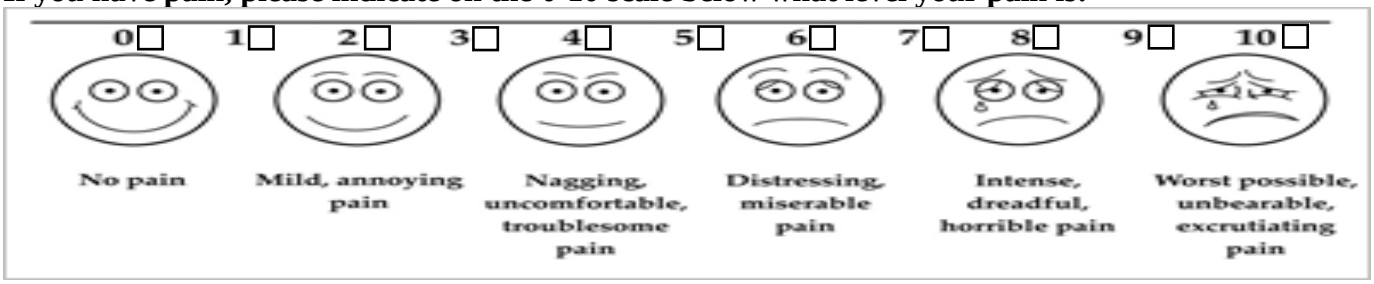
Do you have a pacemaker or defibrillator? Yes☐No☐

Please check (√) any of the following whose care you're under:

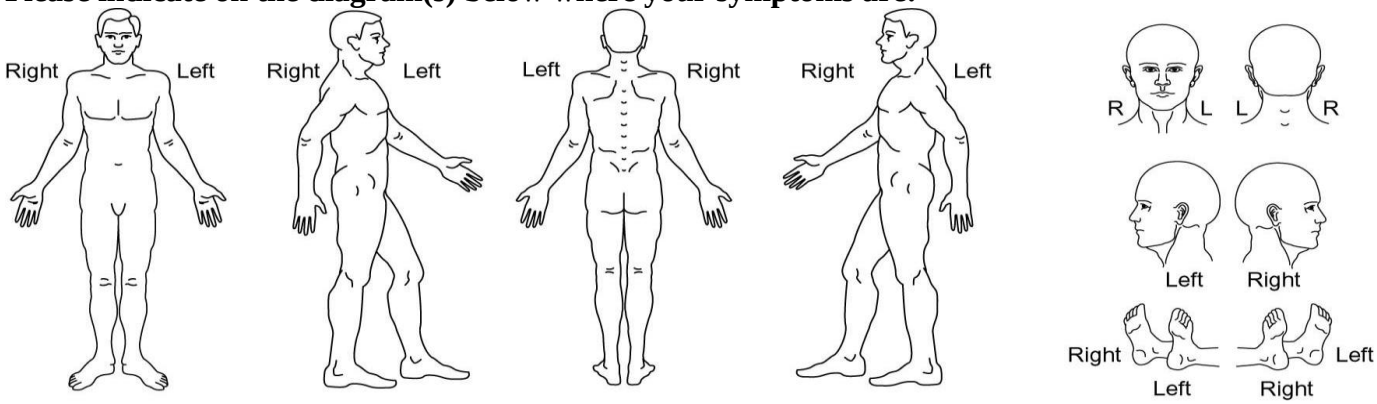
_☐_ Medical Doctor (MD)
_☐_ Osteopath Doctor (DO)
_☐_ Dentist
_☐_ Physiatrist
_☐_ Physical Therapist
_☐_ Chiropractor
_☐_ Psychologist / Social Worker
_☐_ Occupational / Speech Therapist
Other: _____

If you have seen any of the above during the past 3 months, please describe for what reason (illness, injury, physical, etc.): _____

If you have pain, please indicate on the 0-10 scale below what level your pain is:



Please indicate on the diagram(s) below where your symptoms are:



What is the reason you are here today? _____

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Have you ever been diagnosed as having any of the following conditions?

Yes☐No☐ Cancer If yes, what kind? _____
Yes☐No☐ High blood pressure
Yes☐No☐ Heart Disease / Problems ; list; _____
Yes☐No☐ Circulation Problems
Yes☐No☐ Stroke : date; _____
Yes☐No☐ Asthma
Yes☐No☐ Chemical Dependency
Yes☐No☐ Thyroid Problems
Yes☐No☐ Diabetes
Yes☐No☐ Kidney disease
Yes☐No☐ Anemia

Yes☐No☐ Epilepsy
Yes☐No☐ Osteoarthritis ; where; _____
Yes☐No☐ Rheumatoid Arthritis
Yes☐No☐ Other Arthritic Conditions: _____
Yes☐No☐ Multiple Sclerosis
Yes☐No☐ Emphysema / Chronic Bronchitis
Yes☐No☐ Lyme Disease
Yes☐No☐Liver Disease
Yes☐No☐Tuberculosis
Other: _____

Please list any surgeries or other conditions for which you have been hospitalized.

Reason	Date
1. _____	_____
2. _____	_____
3. _____	_____

Please list any significant injuries that you have been treated for?

Reason	Date
1. _____	_____
2. _____	_____
3. _____	_____

Please list any prescription medications you are currently taking, dosage and frequency:

1. _____ Dosage:_____ Freq.: _____ 2. _____ Dosage: _____ Freq: _____
3. _____ Dosage:_____ Freq.: _____ 4. _____ Dosage: _____ Freq.: _____
5. _____ Dosage:_____ Freq.: _____ 6. _____ Dosage: _____ Freq.: _____

Which of the following over-the counter medications have you taken in the last two weeks?

Yes ☐ **No**☐Aspirin
Yes ☐ **No**☐Tylenol
Yes ☐ **No**☐Advil / Motrin / Ibuprofen
Yes ☐ **No**☐Laxative
Other: _____

Yes ☐ **No**☐Antihistamine
Yes ☐ **No**☐Decongestants
Yes ☐ **No**☐Antacids
Yes ☐ **No**☐Vitamins / Minerals/ Supplements

Have you recently noted:

Yes ☐ **No** ☐ Weight loss / gain
Yes ☐ **No** ☐ Nausea
Yes ☐ **No** ☐ Fatigue

Yes ☐ **No** ☐ Weakness : where? _____
Yes ☐ **No** ☐ Fever / Chills / Sweats
Yes ☐ **No** ☐ Numbness / Tingling: where? _____

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction, which include but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic conditions.

I understand that to evaluate/treat my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination/treatment is performed by observing and/or palpating the perineal region, including vaginal and/or rectum. This evaluation and/or treatment will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation/treatment may include vaginal or rectal sensors for muscle biofeedback.

Signature:_____ Date:_____