Saint Thomas Outpatient Rehabilitation

Saint Thomas Health

Men's Health Intake Form

Name: ____ **Date of Birth:** ________________________
Preferred contact (email, phone, etc.): ____

Medical Diagnosis: ____

Physician(s): ____

Date returning to physician: ____

Date of injury/surgery/onset: ____

Reason(s) for seeking therapy:
____
____

Past Medical History :

Previous Surgeries:

Do You Currently Exercise?
- ○ **Sedentary (No exercise)**
- ○ **Mild Exercise (Walk a few blocks, climb stairs, golf)**
- ○ **Occasional Vigorous Exercise (Less than 30 min, 4x/week)**
- ○ **Regular Vigorous Exercise (30 min or more, 4x/week or more)**

Bowels:

How often do you have a bowel movement?______________________________

Do you experience constipation?	**Yes**	**No**

How do you manage it?______________________________

Do you strain to empty your bowels?	**Yes**	**No**
Do you experience diarrhea?	**Yes**	**No**

How do you manage it?______________________________

Do you experience leakage of gas/feces?	**Yes**	**No**

If yes, with what types of activities?______________________________

Daily Fluid Intake:

How much do you drink on an average day?______________________________

Types of fluid:______________________________

Do you restrict your fluids?	**Yes**	**No**

Bladder:

How often do you urinate per day?______________________________

How often do you urinate at night?______________________________

Do you leak urine?	**Yes**	**No**
Coughing/Sneezing/Laughing	**Yes**	**No**
Lifting/Standing Up/Exercise	**Yes**	**No**
Strong Urge	**Yes**	**No**

Other:______________________________

Do your dribble urine?	**Yes**	**No**
Pain or Burning with urination?	**Yes**	**No**
Straining/Pushing to empty bladder?	**Yes**	**No**
Difficulty initiating a stream?	**Yes**	**No**
Feel that you cannot empty the bladder fully?	**Yes**	**No**

Sexual Function:

Are you currently sexually active?	**Yes**	**No**
Do you have difficulty with arousal?	**Yes**	**No**

If yes: ______________________________

Do you have difficulty with erection?	**Yes**	**No**

If yes:______________________________

Do you have difficulty with ejaculation?	**Yes**	**No**

If yes:______________________________

Do you have back pain?	**Yes**	**No**
Do you have abdominal pain?	**Yes**	**No**
Pain with intercourse?	**Yes**	**No**
Pain with ejaculation?	**Yes**	**No**
Pain with urination?	**Yes**	**No**
Pain with bowel movements?	**Yes**	**No**
Pain with arousal?	**Yes**	**No**
Pain with erection?	**Yes**	**No**
Pain with prostate examination?	**Yes**	**No**

Are there other concerns you would like to discuss with your physical therapist?

____
____
____

Please rate your current pain on a 0-10 scale, where 0= No Pain:

____

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

Please indicate the location and type of pain on the drawing provided: