PELVIC THERAPY AND FITNESS LLC
2500 W. Higgins Road Suite 1100, Hoffman Estates, IL 60169
ptf@pelvictherapyfitness.com
847-989-1491

PATIENT INTAKE FORM

Please complete these intake forms before your first appointment and return them via email. Please reach out with any questions, and we look forward to meeting you.

Name _____ Date of Birth _____

Address _____ Emergency Contact _____ Phone _____

Phone _____ Relationship to Patient _____

E-mail _____

Referring Doctor _____ Phone _____

Consent to the following

Text Messages ☐ Yes ☐ No Clinic Information E-mails ☐ Yes ☐ No

Voicemail ☐ Yes ☐ No Marketing E-mails ☐ Yes ☐ No

Mobile Carrier _____

Health Information

Current Concern(s):

Do you get regular physicals? ☐ Yes ☐ No

Do you feel like you're in generally good health? ☐ Yes ☐ No (Please discuss with therapist)

What medications do you take and please include frequently used dietary supplements and non- prescription medications? You may also bring a pre-printed list.

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For Women

Do you get regular periods? ☐ Yes ☐ No

Are your periods painful? ☐ Yes ☐ No

Could you be pregnant? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

If so, are you using assisted fertility treatments? ☐ Yes ☐ No

How many.... Pregnancies? _____ Births? _____

Vaginal? _____ C-Section? _____

Health History

**Check and describe any health conditions you experience(d).

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Stroke/TIA
- ☐ Pacemaker/Defribilator
- ☐ High Blood Pressure
- ☐ Osteoarthritis
- ☐ Infectious Diseases
- ☐ Headaches
- ☐ Dizziness/Fainting
- ☐ Hernia
- ☐ Epilepsy/Seizures
- ☐ Thyroid Problems
- ☐ Bowel/Bladder Problems
- ☐ Endometriosis
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Parkinson's Disease
- ☐ Osteoporosis
- ☐ Diabetes

Surgical History

Have you ever had surgery? ☐ Yes ☐ No

Please list all past surgeries including dates.

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Do you feel safe from violence, coercion, and abuse at home? ☐ **Yes** ☐ **No**

If not, we can direct you to social service agencies that can assist you. It's safe to tell us.

We will rely upon the information you have provided in treating you. By signing below, you attest that this information is accurate to the best of your knowledge.

Patient Name: _____

Patient/ Guardian Signature: _____

Date: _____