

Meredy Parker Physical Therapy

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**Name:** \_\_\_\_\_

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## Postpartum Screening Intake Evaluation

### **PREGNANCY INFORMATION:**

Weight gained during pregnancy: \_\_\_\_\_

Did you exercise during your pregnancy? If yes, what type of exercise did you do?

How many times per week? \_\_\_\_\_ How long was an average workout?

Would you consider yourself hypermobile (i.e. loose-jointed) generally? \_\_\_\_\_

Did you experience back or pelvic girdle pain during your pregnancy? \_\_\_\_\_

Did you seek any health care for this and if so from whom (Dr. Physio. Massage, Chiro) \_\_\_\_\_

Did you experience urinary incontinence during your pregnancy? \_\_\_\_\_

Did you seek any health care for this and if so from whom (Dr. Physio, Massage, Chiro) \_\_\_\_\_

### **BIRTH EXPERIENCE INFORMATION:**

How many children do you have? \_\_\_\_\_ How old are they now? \_\_\_\_\_

Type of birth for each: vaginal or C-section \_\_\_\_\_

For each birth if vaginal, how long was the pushing phase? \_\_\_\_\_ If C-section was it planned or emergency? \_\_\_\_\_

Did you have an episiotomy or tear with any of your births? \_\_\_\_\_

Do you have a diastasis (abdominal separation)? \_\_\_\_\_

### **POSTPARTUM HEALTH CHECK:** Check the following that apply to you now:

\_\_\_ Non-resolving hemorrhoids

\_\_\_ Constipation or difficult with evacuation of bowel (straining)

\_\_\_ Urinary Incontinence with cough, sneeze

\_\_\_ Urgency (feeling a need to go (bladder or bowel) right now but can hold it until you reach the toilet)

\_\_\_ Urgency and incontinence (can't quite make it to the toilet without leaking)

\_\_\_ Back pain and/or pelvic girdle pain

- Pain in other joints of the lower extremity
  - Clicking in your pubic symphysis or sacroiliac joints (front or back of pelvis)
  - Difficulty breathing, feeling short of breath
  - Painful intercourse
- Are you currently exercising? If yes, describe type, frequency and duration of workouts.

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**LIFESTYLE FACTORS**

Are you breastfeeding? \_\_\_\_\_ How often? \_\_\_\_\_  
How much sleep are you getting each night? \_\_\_\_\_  
What are your daily responsibilities? (Cooking, cleaning, working, errands, baby care...)

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**PREVIOUS MEDICAL HISTORY**

- Surgeries: please list \_\_\_\_\_
- Trauma (i.e. fall on tailbone, fractures, MVAs) \_\_\_\_\_
- Chest infection/asthma \_\_\_\_\_
- Ovarian cysts or fibroids \_\_\_\_\_
- Endometriosis \_\_\_\_\_

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### PATIENT SPECIFIC FUNCTIONAL SCALE

Please identify up to 3 important activities that you are unable to do or have difficulty performing as a result of your problem. After you have written down these activities please indicate the degree of difficulty that you are having by scoring each activity on a scale of 0 – 10, (0 = unable to perform the activity, 10 = Able to perform it at pre-injury levels).

Activity # 1.

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0 1 2 3 4 5 6 7 8 9 10

Activity # 2.

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0 1 2 3 4 5 6 7 8 9 10

Activity # 3.

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0 1 2 3 4 5 6 7 8 9 10

### P4 PAIN INTENSITY MEASURE

When answering these questions below, think only of the pain you are experiencing in relation to the problem for which you are having treatment. Circle one number for each of the four questions.

On average, how bad has your pain been: 0= no pain and 10= as bad as it can get

**In the morning over**

**the past 2 days:** 0 1 2 3 4 5 6 7 8 9 10

**In the afternoon over**

**the past 2 days:** 0 1 2 3 4 5 6 7 8 9 10

**In the evening over**

**the past 2 days:** 0 1 2 3 4 5 6 7 8 9 10

**With activity over**

**the past 2 days:** 0 1 2 3 4 5 6 7 8 9 10