



PEDIATRIC HEALTH INTAKE FORM

Please answer all questions as this will help us manage your child's care better.

Patient History and Symptoms:

Name of parent or guardian completing form: _____

Child's name: _____ Age: _____ Height: _____ Weight: _____

When did the problem first begin? _____

Since that time is it: ___ staying the same ___ getting worse ___ getting better

Doctor name and date of the child's last visit: _____ Date of last urinalysis: _____

Previous tests for condition child is coming to PT for:

1. _____
2. _____
3. _____

<u>Medications (prescription & over the counter)</u>	<u>Start Date</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child have or had a history of the following?

- | | |
|---|--|
| <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Latex sensitivity/allergy |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Kidney infection, bladder infections | <input type="checkbox"/> Vesicoureteral reflex Grade _____ |
| <input type="checkbox"/> Neurological Impairments (brain, nerves) | <input type="checkbox"/> Physical or sexual abuse/trauma |

Please explain YES responses:



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Bladder Habits:

1. How often does your child urinate during the day? _____ x per day, every _____ hours.
2. How often does your child wake up to urinate after going to bed? _____ times
3. Does your child awaken wet in the morning? Yes No if yes, _____ days per week.
4. Does your child have the sensation (urge) when they need to urinate? Yes No
5. How long does your child delay going to the toilet once he/she needs to urinate?
 Not at all 1-2 minutes 3-10 minutes
 11-30 minutes 31-60 minutes Hours _____
6. Does your child take time to go to the toilet and empty their bladder? Yes No
7. Does your child have difficulty initiating their stream of urine? Yes No
8. Does your child have a slow, stop/start or hesitant stream? Yes No
9. Does your child have the feeling their bladder is still full after urinating? Yes No
10. Does your child have dribbling after urination? Yes No
11. Fluid intake:
_____ of glasses per day (8 oz or 1 cup)
_____ of caffeinated/glasses per day
Types of drinks:

12. Does your child leak urine throughout the day? Yes No
If yes, what activities:



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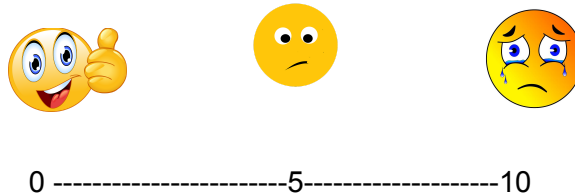
Bowel Habits:

1. How many bowel movements: _____ per day _____ per week
2. Does your child strain to go? Yes No
3. Does your child have fecal staining on his/her underwear? Yes No, how often? _____
4. Does your child have a history of constipation? Yes No For how long?

Does your child wear protection? (pads, diapers, pull-ups) Yes No

Has your child stopped or been unable to do certain activities because of their condition? (For example, embarrassed to play with friends, can't go on sleepovers, feels ashamed about leakage and avoids play dates.) Yes or No

Ask your child to rate his/her feelings as to the severity of this problem from 0-10





Pediatric Parental Consent for Evaluation and Treatment

I _____, hereby give permission to *Physical Therapy for Women Lymphedema and Pelvic Rehab Center*, to provide my minor/child, _____, under my guardianship with receiving and participating in Physical therapy as deemed appropriate. I understand that I am financially responsible for the minor and that all statements contained in the consent apply equally to myself and the minor/child. I consent for my minor/child receiving and participating in physical therapy in accordance with the facility operating policies in my absence under the following conditions:

1. In the presence of another adult family member: Yes No

An adult 18 or older that I designate below, will attend with my minor/child:

Name: _____ Relationship to minor: _____

Name: _____ Relationship to minor: _____

2. When child is under indirect supervision by designated adult family members: Yes No

Informed consent for treatment and assessment of the pelvic floor muscles : (if applicable)

I understand that to evaluate my condition, it may be necessary to initially and periodically have my therapist perform a pelvic floor muscle examination. This examination is performed by observing and/or palpation the external perineal region. No internal examination is done unless the minor has had a pelvic floor examination by her doctor and/or is currently sexually active and agrees to an internal examination. This evaluation will assess skin condition, reflexes, muscle tone, length, strength & endurance, and function of the pelvic floor.

I understand my child/minor's treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and educational instruction.

Release of medical records: I authorize the release of my medical records to my physicians or primary care provider or insurance company.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled with my child/minor unless there are unusual circumstances that prevent me. I agree to cooperate with and carry out the home physical therapy program assigned to my child.

Cancellation Policy: Our goal is to provide quality, individualized physical therapy in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need therapy. I understand that if I cancel less than 3 hours in advance, **I will pay a cancellation fee of \$50.00.**



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nd that my therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding results of condition for my treatment.

I certify that I have read and understand all the terms of this consent and agree to continue to abide by all of the terms of this consent.

Patient Name: _____ Date: _____

Patient Signature

Signature of Parent or Guardian