METROPARTNERS OBGYN
PREMIER WOMEN'S HEALTH
OF MINNESOTA

Intake form for Dr Katherine Shephard, PT, DPT

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential. If you have any questions, please reach out to the clinic.

Name: _____

Pronouns: _____

Date of Birth (MM-DD-YYYY):_____

Mobile Number: (Required for SMS appointment reminders) _____

Home Number:_____

Address:_____

_____

Occupation:_____

Emergency Contact: (Name, Relationship & Phone Number):

_____

Name of referring professional (If applies): _____

Referring professional phone number (If Known):_____

Questionnaires

Please complete the following questions before your scheduled appointment. **** Indicates a required field***

List any other major medical conditions or injuries you have/had*_____

_____

_____

_____

List any past surgeries*_____

_____

_____

_____

Have you had any imaging/scans taken? If so, do you know the results? *_____

_____

_____

_____

List all medications you are currently taking, including any over-the-counter medications, herbs, or vitamins. Please include dosage, frequency, and reason for taking: *_____

_____

_____

_____

How would you describe your general state of health?

__ Excellent __Good __Fair __Poor

Medical History

Please check all that apply:

- [ ] Poor Sleep
- [ ] Hearing Impairment
- [ ] Vision Changes
- [ ] Bladder/Bowel Changes
- [ ] Headaches
- [ ] Decreased Mobility
- [ ] Seizures
- [ ] Arthritis
- [ ] Cancer
- [ ] Diabetes
- [ ] Osteoporosis/Osteopenia
- [ ] Mental Health
- [ ] None of the Above
- [ ] Dizzy/Lightheaded
- [ ] Discoordination
- [ ] Nausea/Vomiting
- [ ] Weight Changes
- [ ] Bleeding Problems
- [ ] Implanted Device
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Shortness of Breath
- [ ] Asthma
- [ ] GI Condition
- [ ] Any falls within the last 6 months

Current emotional stress scale (O- No Stress / 10 - Extremely Stressed)

Do you smoke? ____Current _____ Never _____Past

Do you drink alcohol? ____Current _____ Never _____Past

Do you use recreational drugs? ____Current _____ Never _____Past

Do you have chronic pain? ____Current _____ Never _____Past

Activity Level:

__Sedentary __Light __Moderate __Active __Extremely Active

What specifically brings you to therapy? When did your symptoms begin? _____

_____

_____

_____

Have you seen any other healthcare providers for this condition? If yes, when and what was the diagnosis (if any)?

_____

_____

_____

How is this affecting your life (relationships, getting around, socializing, etc.)? _____

_____

_____

_____

What makes it worse?

_____

_____

_____

What makes it better?

_____

_____

_____

Are you (or could you be) pregnant? If yes, what is your estimated due date? _____

How many pregnancies have you had? _____

Number of vaginal deliveries: _____

Number of cesarean deliveries: _____

What else would you like your physical therapist to know? _____

_____

_____

_____

Consent for Physical Therapy

I hereby authorize Katherine Shephard and/or such assistants to provide physical therapy services. I acknowledge that the purpose of physical therapy is to diagnose and treat disease, injury, and disability by use of rehabilitative procedures, mobilization, massage, exercise, and physical agents to aid in achieving maximum potential, accelerating recovery and reducing the length of functional impairment. I understand that all procedures will be thoroughly explained to me before I am asked to perform them.

I accept the treatment recommendation of my physical therapist. I acknowledge that no warranty or guarantee has been made as to the results of this therapy. I understand that any aspect of this consent form that I do not understand will be explained to me in further detail by asking my physical therapist. It is my right to ask my physical therapist about the treatment plan based on my individual history, physical therapy diagnosis, symptoms, and examination results. I further certify that my physical therapist has informed me of the nature and character of the proposed treatment, of the anticipated result, alternative treatment choices, and the possible risks, complications, and anticipated benefits involved in the proposed therapy.

I consent, by my own free will, to voluntarily engage in an in-person session or Telehealth/virtual session through telephone or video conferencing.

_____ _____

Signature Date

Please check that all required questions have been answered.