Diane Lee & ASSOCIATES
CONSULTANTS IN PHYSIOTHERAPY

**Name:**_____

**Email:**_____

# Postpartum Screening Intake Evaluation

**PREGNANCY INFORMATION:**
Pre-pregnancy weight: _____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.
_____

**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…)
_____
_____
_____

**PREVIOUS MEDICAL HISTORY**
___Surgeries, please list_____
___Trauma (i.e. fall on tailbone, fractures, MVAs)_____
___Chest infection/asthma_____
___Ovarian cysts or fibroids
___Endometriosis

## 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 difficult 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.

_____.

0 1 2 3 4 5 6 7 8 9 10

Activity # 2.

_____

0 1 2 3 4 5 6 7 8 9 10

Activity # 3.

_____.

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:

| | **No Pain** | | | | | | | | | | **Pain as Bad as it could be** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 |

TOTAL /40