Pelvic Health - Female

File #: _____

Date: _____

Waterdown Village Chiropractic & Wellness Group

255 Dundas Street East
Unit #14A
Waterdown, ON L8B 0E5
T 905·689·4440
F 905·689·4441
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General Information

How do you wish to be addressed in our office?

☐ First name ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

How do you wish to be contacted by our office regarding your appointments?

☐ Email ☐ Phone

Last Name: _____ **D.O.B.** _____

First Name: _____ **Sex:** ☐ M ☐ F

Address: _____

Town/City: _____ **Province:** _____ **Postal Code:** _____

Home Phone: ( ) _____ **Cell Phone: ( )** _____

Email: _____ _____ **Please Initial** Consent to receive email communication from the clinic

Occupation: _____ **Spouse's name (if applicable):** _____

Children: Y N **Number:** _____ **Ages:** _____

(Females) Are you pregnant? Y N **How many weeks?** _____ **Estimated Due Date:** _____

Family Dr. Name: _____ **Phone: ( )** _____

Previous Wellness Care? (check all that apply)

☐ Chiropractic ☐ Physiotherapy ☐ Naturopathy ☐ Massage Therapy ☐ Osteopathy

Location: _____

Referred by: _____

How did you decide to choose our office? _____

Reason for consulting the office:

- ☐ I have a specific problem and require help only with this problem.
- ☐ After my specific problem has been relieved, I am interested in strategies for maintenance.
- ☐ After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
- ☐ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

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Female Pelvic Health Intake

Presenting problems:

1. _____
2. _____

When did this start? _____

Occupation/hobbies: _____

Please fill out each section that is relevant to your specific health issue:

A. Gynecological History

What age did your period start? _____

Is your cycle regular? ☐ **Yes** ☐ **No**

How long is your cycle? _____

Do you suffer from PMS? ☐ **Yes** ☐ **No**

Is your bleeding heavy? ☐ **Yes** ☐ **No**

Do you have pain with your period? ☐ **Yes** ☐ **No** If yes, when? _____

Do you use tampons? ☐ **Yes** ☐ **No**

Do you have pain with insertion of a tampon? ☐ **Yes** ☐ **No**

Do you have excessive discharge? ☐ **Yes** ☐ **No**

Are you sexually active? ☐ **Yes** ☐ **No**

Are you using any form of birth control? ☐ **Yes** ☐ **No** Type: _____

Do you experience pain with intercourse? ☐ **Yes** ☐ **No**

Have you gone through menopause? ☐ **Yes** ☐ **No** If so, when? _____

Do you suffer from vaginal dryness? ☐ **Yes** ☐ **No**

Are you on hormone replacement therapy? ☐ **Yes** ☐ **No** If yes, what? _____

Do you use lubrication? ☐ **Yes** ☐ **No** What type: _____

File #: _____

B. Pregnancy and Birth History

# of pregnancies? _____ # of live births _____

Weight of heaviest baby _____ lbs _____ oz

Length of pushing stage _____ hours

# of C-sections _____ # of vaginal deliveries _____

Did you have an epidural? ☐ **Yes** ☐ **No**

Did you have a vacuum-assisted delivery? ☐ **Yes** ☐ **No** Forceps? ☐ **Yes** ☐ **No**

Have you had any episiotomies? ☐ **Yes** ☐ **No** Any tearing? ☐ **Yes** ☐ **No**

During my labour(s) and delivery, I felt supported and cared for:

☐ **All or most of the time** ☐ **Some of the time** ☐ **A little bit of the time** ☐ **Not at all**

Were there times during labour & delivery that you were, or thought you were, in danger of death or injury? ☐ **Yes** ☐ **No**

Were there times when the baby was or seemed to be in danger during labour & delivery? ☐ **Yes** ☐ **No**

Do suffer or have you suffered from post-partum depression? ☐ **Yes** ☐ **No**

Do you have feelings of heaviness/pressure in your vagina? ☐ **Yes** ☐ **No**

Have you ever been told you have a prolapse? ☐ **Yes** ☐ **No**

C. Have you had any of the following medical procedures? *(check all those that apply)*

☐ Appendectomy	☐ Bartholin Cyst	☐ Bowel Resection
☐ Laparoscopy	☐ Cystoscopy	☐ Colostomy
☐ TVT-TVT(O)	☐ Gallbladder Removal	☐ Hemorrhoid Surgery
☐ Mesh Procedure	☐ Prolapse / Vaginal Repair	☐ Hysterectomy
Other:		

D. Bladder Symptoms

Did you have problems with your bladder during childhood?	**Yes**	**No**	**Sometimes**
Do you have leakage associated with sneezing, coughing, running and/or laughing?	**Yes**	**No**	**Sometimes**
Do you have leakage during intercourse?	**Yes**	**No**	**Sometimes**
Do you have difficulty starting your urine stream?	**Yes**	**No**	**Sometimes**
Do you have dribbling after you get up from the toilet?	**Yes**	**No**	**Sometimes**
Do you sit on the toilet?	**Yes**	**No**	**Sometimes**
Do you have pain when your bladder fills?	**Yes**	**No**	**Sometimes**

Do you feel really strong sensations prior to voiding but don't leak?	**Yes**	**No**	**Sometimes**
Does your leakage occur after having a strong urge that feels uncontrollable?	**Yes**	**No**	**Sometimes**
Do you have to strain to empty your bladder?	**Yes**	**No**	**Sometimes**
Do you have pain when you void / urinate?	**Yes**	**No**	**Sometimes**
Does your pain improve when you void / urinate?	**Yes**	**No**	**Sometimes**
Do you have incomplete emptying when you void and feel like you have to go again soon after?	**Yes**	**No**	**Sometimes**
Do your bladder problems cause you to leak at night?	**Yes**	**No**	**Sometimes**
Does your incontinence fluctuate with your cycle?	**Yes**	**No**	**Sometimes**
Does your incontinence require you to wear pads?	**Yes**	**No**	**Sometimes**
Do you void during the day more than the average (5-7x/day)?	**Yes**	**No**	**Sometimes**

If you answered yes or sometimes, how often? _____

Fluid intake in 24 hours

_____ cups of water/day; _____ cups of coffee/day; _____cups of tea/day _____

_____cups of other fluids/day; _____alcoholic drinks/day/week/month

Do you have any food allergies or sensitivities? _____

_____

_____

Digestion & Bowel Function:

What is the frequency of your bowel movements? _____

Do you regularly feel the urge to move your bowels?	**Never**	**Seldom**	**Always**
Do you have constipation?	**Never**	**Seldom**	**Always**
Do you strain to have a bowel movement?	**Never**	**Seldom**	**Always**
Do you have loose stools/diarrhea?	**Never**	**Seldom**	**Always**
Do you have bowel urgency that is difficult to control?	**Never**	**Seldom**	**Always**
Do you lose control of your bowels?	**Never**	**Seldom**	**Always**
Do you have incomplete emptying?	**Never**	**Seldom**	**Always**
Do you have pain with a bowel movement?	**Never**	**Seldom**	**Always**

File #: _____

Do you have pain after a bowel movement? **Never** **Seldom** **Always**

Does it take longer than 5 minutes to have a bowel movement? **Never** **Seldom** **Always**

Do you have bloating (increased pressure in abdomen)? **Never** **Seldom** **Always**

Do you have a physical change in abdominal girth when bowels are full? **Never** **Seldom** **Always**

In your opinion, is your fibre intake: **Too Low** **Adequate** **Too High**

Do you regularly use □ laxatives □ stool softeners □ natural products □ enemas

Have you ever been diagnosed with/think you have?

Irritable bowel syndrome When? _____Who? _____

Ulcerative colitis When? _____Who? _____

Crohn's Disease When? _____Who? _____

Celiac Disease When? _____Who? _____

E. Medical History:

Urinary tract infections □ **Yes** □ **No** How often? _____

Antibiotics recently? □ **Yes** □ **No** Last UTI? _____

Probiotics? □ **Yes** □ **No** Cranberry supplementation? □ **Yes** □ **No**

Smoker □ **Yes** □ **No** # _____ packs/day

Chronic cough? □ **Yes** □ **No**

Yeast infections □ **Yes** □ **No** How often?

Last infection Treatment _____

Do you get blood in your urine? □ **Yes** □ **No**

Allergies (including latex): □ **Yes** □ **No**

Low back problems □ **Yes** □ **No** Chronic? □ **Yes** □ **No**

Mid back problems □ **Yes** □ **No** Chronic? □ **Yes** □ **No**

Neck problems □ **Yes** □ **No** Chronic? □ **Yes** □ **No**

Have you ever been treated for depression? □ **Yes** □ **No** What treatment? _____

Have you ever been treated for anxiety? □ **Yes** □ **No** What treatment?

On a scale from 1-10, please circle and rate how much your pelvic health problems bother you

1 2 3 4 5 6 7 8 9 10

On a scale from 1-10, please circle and rate how motivated you are to correct these problems

1 2 3 4 5 6 7 8 9 10

File #: _____

DASS Questionnaire

Please read each statement and circle a number, 0 1, 2, or 3, which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any one statement.

S= _____ A= _____D=_____

0 = It does not apply to me at all

1 = Applies to me to some degree or some of the time

2 = Applies to me a considerable degree, or a good part of the time

3 = Applies to me very much, or most of the time

I found it hard to wind down	**S**	0	1	2	3
I was aware of dryness of my mouth	**A**	0	1	2	3
I could not seem to experience any feeling at all	**D**	0	1	2	3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness, etc…)	**A**	0	1	2	3
I found it difficult to work up the initiative to do things	**D**	0	1	2	3
I tended to over-react to situations	**S**	0	1	2	3
I experienced trembling (e.g. in hands)	**A**	0	1	2	3
I felt that I was using a lot of nervous energy	**S**	0	1	2	3
I was worried about situations in which I might panic and make a fool of myself	**A**	0	1	2	3
I felt that I had nothing to look forward to	**D**	0	1	2	3
I found myself getting agitated	**S**	0	1	2	3
I find it difficult to relax	**S**	0	1	2	3
I felt down-hearted and blue	**D**	0	1	2	3
I am intolerant of anything that kept me from getting on with what I was doing	**S**	0	1	2	3
I felt I was close to panic	**A**	0	1	2	3
I was unable to become enthusiastic about anything	**D**	0	1	2	3
I felt I was not much of a person	**D**	0	1	2	3
I felt rather touchy	**S**	0	1	2	3
I am aware of the action of my heart in the absence of physical exertion	**A**	0	1	2	3
I feel scared without any good reason	**A**	0	1	2	3
I felt that life is meaningless	**D**	0	1	2	3