Pelvic Health - Male

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
E info@wvchirogroup.ca

wvchirogroup.ca

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: ______________________________

____________ Consent to receive email
Please Initial 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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Male 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. Have you had any of the following medical procedures? *(check all those that apply)*

Appendectomy	Hernia Repair	Bowel Resection
Hemorrhoid Banding	Prostatectomy	Cystoscopy
Urodynamics	Gallbladder Removal	Colostomy
Vasectomy	Other:	

B. 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 sometimes 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 stand to void?	**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**

File #: ________________________

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? ____

____

____

C. 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**

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

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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? _____________________

D. Prostate / Penile Health

Last PSA score: ____________________ When? ________________

Last digital rectal exam? ____

Does your prostate get painful/irritated? □ **Yes** □ **No**

Has your prostate fluid been expressed and tested? □ **Yes** □ **No**

Do you have painful erections? □ **Yes** □ **No**

Can you achieve satisfactory erection? □ **Yes** □ **No**

Do you have premature ejaculation? □ **Yes** □ **No**

Do you have pain during intercourse? □ **Yes** □ **No**

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**

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

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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