Waterdown Village Chiropractic & Wellness Group

255 Dundas Street East
Unit #14A
Waterdown, ON L8B 0E5
T 905·689·4440
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wvchirogroup.ca

File #: ______________________

Date: ______________________

General Information

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

First Name: ______________________

How do you wish to be addressed in our office? *(First Name, Mr., Mrs., Dr., Nickname, Etc...)*

____

Identify as? M F Other: **Sex at birth:** M F

Address: ______________________

Town/City: ______________ **Province:** ________ **Postal Code:** ______________

Home Phone: ______________ **Cell Phone:** ______________

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

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

Email Phone

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:** ______________

Current / Previous Wellness Care? *(check all that apply)*

Chiropractic Physiotherapy Naturopathy Massage Therapy Osteopathy

Location: ______________________

How did you hear about us? ***(referral, ad, Google)*** ______________________

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?	Y	N	

How long is your cycle? ____

Do you suffer from PMS?	Y	N	
Is your bleeding heavy?	Y	N	
Do you have pain with your period?	Y	N	

If yes, when? ____

Do you use tampons?	Y	N	
Do you have pain inserting a tampon?	Y	N	
Do you have excessive discharge?	Y	N	
Are you sexually active?	Y	N	
Are you using any form of birth control?	Y	N	Type: ____________________
Do you experience pain with intercourse?	Y	N	
Have you gone through menopause?	Y	N	Date: ____________________
Do you suffer from vaginal dryness?	Y	N	
Are you on hormone replacement therapy?	Y	N	Type: ____________________
Do you use lubrication?	Y	N	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?	Y	N			
Did you have a vacuum-assisted delivery?	Y	N	Forceps?	Y	N
Have you had any episiotomies?	Y	N	Any tearing?	Y	N

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?

Y   N

Were there times when the baby was or seemed to be in danger during labour & delivery?	Y	N
Do suffer or have you suffered from post-partum depression?	Y	N
Do you have feelings of heaviness/pressure in your vagina?	Y	N
Have you ever been told you have a prolapse?	Y	N

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?	Y	N	Sometimes
Does your leakage occur after having a strong urge that feels uncontrollable?	Y	N	Sometimes
Do you have to strain to empty your bladder?	Y	N	Sometimes
Do you have pain when you void / urinate?	Y	N	Sometimes
Does your pain improve when you void / urinate?	Y	N	Sometimes
Do you have incomplete emptying when you void and feel like you have to go again soon after?	Y	N	Sometimes
Do your bladder problems cause you to leak at night?	Y	N	Sometimes
Does your incontinence fluctuate with your cycle?	Y	N	Sometimes
Does your incontinence require you to wear pads?	Y	N	Sometimes
Do you void during the day more than the average (5-7x/day)?	Y	N	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

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
Is there 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	Y	N	How often? ____________________		
Antibiotics recently?	Y	N	Last UTI? ____________________		
Probiotics?	Y	N	Cranberry supplementation?	Y	N
Smoker?	Y	N	#__________packs / day		
Vaper?	Y	N	Frequency: ____________________		
Chronic cough?	Y	N			
Yeast infections?	Y	N			

Last infection treatment: ____

Blood in urine?	Y	N			
Allergies (including latex)?	Y	N			
Low-back problems?	Y	N	Chronic?	Y	N
Mid-back problems?	Y	N	Chronic?	Y	N
Neck problems?	Y	N	Chronic?	Y	N

Have you ever been treated for depression?	Y	N	What treatment? ______________
Have you ever been treated for anxiety?	Y	N	What treatment? ______________

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

On a scale from 1-10, please rate how motivated you are to correct these problems*:* ____________

DASS Questionnaire

Please read each statement and select 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.

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

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

Total your responses:

S= ___________ A= __________D=___________