

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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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?	Y	N	Sometimes
Do you have leakage associated with sneezing, coughing, running and/or laughing?	Y	N	Sometimes
Do you sometimes have leakage during intercourse?	Y	N	Sometimes
Do you have difficulty starting your urine stream?	Y	N	Sometimes
Do you have dribbling after you get up from the toilet?	Y	N	Sometimes
Do you stand to void?	Y	N	Sometimes
Do you have pain when your bladder fills?	Y	N	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

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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? _____

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	
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

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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?	Y	N
Has your prostate fluid been expressed and tested?	Y	N
Do you have painful erections?	Y	N
Can you achieve satisfactory erection?	Y	N
Do you have premature ejaculation?	Y	N
Do you have pain during intercourse?	Y	N

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	
Blood in your 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= _____