

Patient name: _____ DOB: _____ Date: _____

Symptom Monitor

Presenting problems _____

When did this start? _____

Occupation/hobbies _____

Gynecological History – please complete the following section if this applies to you

What age did your period start? _____ Is your cycle regular? No Yes

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? No Yes If yes, when? _____

Do you use tampons? No Yes Do you have pain with insertion of a tampon? No Yes

Do you have excessive discharge? Yes No Sexually active? No Yes

Birth control? Yes No Type: _____ Pain with intercourse? Yes No

of pregnancies _____ # of live births _____ Wt. heaviest baby _____ lbs _____ oz

Age of child(ren) _____ Length pushing stage _____ hours

of vaginal deliveries _____ # of C-sections _____ Forceps? Yes No

Did you have an epidural? Yes No Did you have a vacuum-assisted delivery? Yes No

Episiotomies? Yes No Tears? Yes No Grade of tear _____

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 Not at all _____

Were there times during labour and 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 you suffer/have you suffered from post-partum depression? Yes No

Have you gone through menopause? Yes No If so, when? _____ Do you suffer from vaginal dryness? Yes No

Hormone replacement therapy Yes No If yes, what? _____

Do you use lubrication? Yes No Sometimes What type: _____

Do you use vaginal moisturizer Yes No Have you ever been told you have a prolapse? Yes No

If yes, what type? _____



Patient name: _____ DOB: _____ Date: _____

Do you physically feel something coming out of your vagina (with your hand) Yes No Do you have feelings of heaviness/pressure in your vagina Yes No

Prostate/Penile Health - please complete the following section if this applies to you

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 a satisfactory erection? No Yes

Do you have premature ejaculation? Yes No

Do you have pain during intercourse? Yes No When? _____

Have you had any of the following medical procedures? If so, please provide the approximate date:

Appendectomy _____ Bartholin Cyst _____ Bowel resection _____

Laparoscopy _____ Cystoscopy _____ Colonoscopy _____

TVT-TVT(O) _____ Gallbladder removal _____ Hemorrhoid surgery _____

Mesh procedure _____ Prolapse/Vaginal repair _____ Hysterectomy _____

Colostomy _____ Vasectomy _____ Prostatectomy _____

Hernia repair _____ Urodynamics _____ Other _____

Bladder Symptoms - please complete the following section if this applies to you

Did you have problems with your bladder during childhood? Yes No Sometimes

Do you have leakage associated with sneezing, coughing, running and/or laughing? Other _____ Yes No Sometimes

Do you have leakage during intercourse? 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 pain when your bladder fills? Yes No Sometimes

Does your pain improve when you void/urinate? Yes No Sometimes

Do you have pain when you void/urinate? Yes No Sometimes

Patient name: _____ DOB: _____ Date: _____

- Do you have to strain in order to empty your bladder? 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? No Yes Sometimes
- Do you have incomplete emptying when you void and feel like you have to go again soon? Yes No Sometimes
- Do your bladder problems cause you to leak in bed 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

If you answered yes or sometimes, how often? _____ Type of pads _____

- Do you void during the day more than the average person (5-7x/day)? Yes No Sometimes

If you answered yes or sometimes, how often? _____

- Do you need to get up at night to void? Yes No Sometimes

If you answered yes or sometimes, how many times? _____

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

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? Always Seldom Never
- Do you strain to have a bowel movement? Always Seldom Never
- Do you splint or assist to pass stool? Always Seldom Never
- Do you have loose stools/diarrhea? Always Seldom Never
- Do you use your finger to help evacuate? Always Seldom Never
- Do you have bowel urgency that is difficult to control? Always Seldom Never
- Do you have accidental bowel leakage? Always Seldom Never
- Do you have incomplete emptying? Always Seldom Never
- Do you have pain with a bowel movement? Always Seldom Never
- Do you have pain after a bowel movement? Always Seldom Never
- Does it take longer than 5 minutes to have a bowel movement? Always Seldom Never
- Do you have bloating? (Increased pressure in abdomen) Always Seldom Never

Patient name: _____ DOB: _____ Date: _____

Do you experience a physical change in abdominal girth when your bowels are full (distension)? Always Seldom Never

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? _____

Do you have any food allergies or sensitivities? _____

Medical History

Urinary tract infections Yes No How often? _____

Antibiotics recently? Yes No Last UTI? _____

Probiotics? No Yes Cranberry supplementation? No Yes

Smoking 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): _____

Do you exercise? No Yes Type: _____ Frequency: _____

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? _____

Is/was treatment effective? No Yes

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

Is/was treatment effective? No Yes

Have you ever been diagnosed with a mental health condition? No Yes If yes, what? _____

Patient name: _____ DOB: _____ Date: _____

On a scale from 1-10, please circle and rate how much this problem bothers 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 this problem

1 2 3 4 5 6 7 8 9 10

20 Questions For Vitamin D Deficiency: Do You Experience The Following Symptoms?

Smooth muscle	Shortness of breath	No	Yes
	Vascular headaches	No	Yes
	Wheezing after exercise	No	Yes
	Frequent urination	No	Yes
	Constipation	No	Yes
Skeletal muscle	Leg cramps	No	Yes
	Muscle tension	No	Yes
	Fasciculations (eg. eye twitches)	No	Yes
	Double vision	No	Yes
	Myalgia	No	Yes
	Restless legs	No	Yes
	Back pain	No	Yes
Cardiovascular	Trigger point pain	No	Yes
	Palpitations	No	Yes
	Arrhythmias	No	Yes
	High blood pressure	No	Yes
Brain	Depression	No	Yes
	Decreased concentration	No	Yes
	Headaches	No	Yes
	Increased anxiety	No	Yes
Other	Dark chocolate craving (especially after period)	No	Yes
	Difficulty falling asleep	No	Yes
	Decreased symptoms after Epsom salt bath	No	Yes

Patient name: _____ DOB: _____ Date: _____

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 statement.

S = _____ A = _____ D = _____

0 = It did not apply to me at all

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

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

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

I find 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 in the absence of physical exertion.....	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. 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 found it difficult to relax.....	S	0	1	2	3
I felt down-hearted and blue.....	D	0	1	2	3
I was 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 that I was rather touchy.....	S	0	1	2	3
I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat).....	A	0	1	2	3
I felt scared without any good reason.....	A	0	1	2	3
I felt that life was meaningless.....	D	0	1	2	3