

Please fill out this questionnaire to the best of your ability. Some of the questions may feel challenging to answer or may seem unrelated to your primary issue. The goal of this health story is to look at you and your life experiences holistically, compassionately and as a tool for education.

Name

Address

Phone

Email

Date of birth

Preferred pronoun

Gender currently identifying as

Gender assigned at birth

How did you hear about me and this work?

Abdominal Therapy is not a substitute for care by your medical doctor. Abdominal Therapy practitioners do not diagnose medical diseases, physical or mental conditions. Abdominal Therapy practitioners do not prescribe medical pharmaceuticals.

## COVID19 Screening

Have you tested positive or had treatment for Covid-19? Yes      No

If yes, when was your test?

Have you tested negative since this time? Yes      No

Have you been following social distancing measures? Yes      No

Do you or have you recently had a fever? Yes      No

Have you, or has anyone you are in close contact with had any of the following signs or symptoms associated with Covid-19:

Fever	Runny nose	Abdominal pain
Chills	Wheezing	Diarrhea
Pink eye	Shortness of breath	Loss of smell & taste
Muscle ache	Chest pain	Long-term chesty cough producing mucus
Sore throat	Headache	
Persistent dry cough	Nausea/vomiting	

I have stated all known conditions and will keep my practitioner updated on my health. By signing below, I confirm all the information I've provided is correct. I understand this information will remain confidential.

Signature

Name

Date

## What's the reason for your visit?

Primary reason for this visit?

What would you like to achieve as a result of your visit?

When did you first notice this?

Do you feel something may have triggered this?

Describe any stressors occurring at this time?

What makes you feel better?

What makes you feel worse?

What changes or goals would you like to achieve over the next 3/6 months?

## A Little bit of History

Are you taking any of the following – medication, supplementation, natural remedies?

If so, please give details:

Do you use alcohol or recreational drugs? If so, how regularly and how do you feel about this?

Do you smoke? If so, how regularly and how do you feel about this?

Any allergies? If yes, what are you allergic to? What reaction do you have?

Have you experienced any of the following? If so, please share some details.

Surgery

Accidents

Injuries to sacrum/head/tailbone

## Concerns

Do you, or have you ever suffered from any of the following:

- |                        |                           |                       |
|------------------------|---------------------------|-----------------------|
| Headache               | Sciatica                  | Sleep disturbance     |
| Asthma                 | Herniated/bulging discs   | Feeling faint         |
| Cold hands/feet        | Painful/swollen joints    | Varicose veins        |
| Swollen ankles         | Neck/shoulder/jaw tension | Cancer (type)         |
| Sinus conditions/colds | High/low blood pressure   | Haemorrhoids          |
| Seizures               | Sore heels when walking   | Numb feet on standing |
| Skin conditions        | Anxiety                   |                       |
| Lower back pain        | Depression                |                       |

## Family Story

Please share any significant details of your birth family story if known; this may include physical or mental health, lifestyle, cause/age of death of your parents and any other details you feel are relevant.

Maternal

Paternal

## Gut Health

Describe your relationship with food?

What were mealtimes like growing up?

What are mealtimes like now?

Do you have any food intolerances or allergies?

Do you follow a particular diet?

Do you eat home cooked food?

Mainly

Occasionally

Never

What is your typical daily intake of the following?

Water

Caffeine

Alcohol

Do you experience any bloating, burbs or flatulence after eating?

Yes

No

If so, what triggers this?

How often are your bowel movements?

Do you suffer from abdominal pain, constipation, diarrhea, incomplete bowel movements, thin stools, blood or mucus in your stools?

# Mental & Emotional Health

How do you nurture yourself?

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Where and how do you find joy?

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Are you currently experiencing stress?

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How do these affect your life and how do you manage them?

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Do you have a faith or spiritual practice and if so, would you be willing to share this?

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What exercise do you enjoy, and how often do you do it?

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Do you experience low mood, anxiety, depression, post-traumatic stress disorder, or any other mental health condition that you are willing to share?

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Have you experienced any traumatic events that you would be willing to share?

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Have you considered seeking professional support?

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## Pelvic Health

Do you experience pelvic pain or congestion?

Yes

No

If so, how does this affect you?

Do you experience pain in any of the following areas?

Uterus

Vulva

Testicles

Perineum

Ovaries

Penis

Rectum

Vagina

Prostate

Pain during sex

Do you experience any of the following urinary issues? If so, how does this affect you?

Incontinence –  
coughing, jumping

Cystitis

Interstitial Cystitis

Bladder prolapse

Overactive bladder

Incomplete bladder  
emptying

Kidney Stones

Bladder stones

Night time urgency

Constant leakage

Bladder cancer

Have you had any pelvic tests – PAP, PSA or STD?

Have you ever had abnormal results?

Yes

No

If so when, and did you receive treatment?

Do you currently/have you use/used birth control? If so, please indicate which one and if hormonal, how long for:

Pill

Diaphragm

Condoms

Abstinence

Fertility Awareness

Patch

Injection

IUD

Rhythm Method

## Menstrual Health

Do you experience any of the following:

Painful periods

Dizziness

Bleeding/spotting during  
ovulation

Absent period

Bowel changes

Premature Ovarian Failure

Lower back pain before/  
during/after bleeding

Headache/migraine

Polyps – uterine/cervical

Irregular cycles

Water retention

Fibroids – location/size/number

Heaviness prior to period

Endometriosis

Cysts – location/size/number

Dark thick blood – start/end

Painful ovulation

Incontinence- bladder/bowel

Excessive bleeding

Irregular ovulation

Vaginal dryness

Clots

Lack of ovulation

Bloating

How old were you when you started menstruating?

What was this like for you?

How many days is your menstrual cycle?

How many days is your bleed?

Please include number of days spotting at beginning or end.

What menstrual products do you use?

Do you bleed through more than one tampon or pad per hour?

When was your last menstrual bleed?

How do you feel about your menstrual cycle?

Do you Chart your cycle?

If so how – App, Paper charts?

Do you know if your mother, sister or other close female relations have experienced any of the following issues?

Infertility

Endometriosis

Menstrual issues

Fibroids

Cancer

Menopause issues

## Urogenital Health

Do you experience or have a history of any of the following:

Painful/burning on urination

Pain/discomfort in -

Prostate disease or cancer

Urinary retention

Testicles

Pelvic injury or surgery

Urinary incontinence or dribbling

Penis

Sperm related fertility issues

Difficult to start urination

Rectum

Vulvodynia

Weak/interrupted urine flow

Inner Thigh

Cystitis

Frequent bladder infections

Pelvic Floor/perineum

Interstitial cystitis

Blood/pus in urine

Erection pain/problems

Herpes

Pelvic pain/pressure

Lower back pain especially

HPV

Night time urination

after sex

Bartholin's cyst

Changes in sex drive

## Desire & Libido

Do you enjoy making love?

Do you climax?

Are you satisfied with your level of sexual desire?

Have you noticed any changes recently?

How do you feel about this?

# Fertility & Pregnancy Health

Are you hoping to conceive?

If so, how long have you been trying?

Have you or your partner had any pregnancies?

Yes

No

If so, did you choose to continue with them and what were they like?

Have you experienced any loss?

Have you given or witnessed birth?

If so what was the experience like?

How was your postpartum experience?

Have you had any fertility tests e.g. Sperm or egg reserve?

Are you under the care of a fertility specialist?

Please describe any treatment you may have received including - IUI, IVF, ICSI, Hormone treatment or Surgery.

## Peri/Menopause Health

How do you feel about your menopausal journey?

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What stories do you carry?

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What positive menopausal role models do you have?

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Are you keeping your menopausal journal?

Do you experience any of the following:

Hot flushes	Insomnia	Flooding	Poor memory
Vaginal discharge	Dry/itchy skin	Tiredness	Mood swings
Increased libido	Dry/itchy vagina	Depression	Irritability
Decreased libido	Vaginal Atrophy	Anxiety	
Painful sex	Spotting	Irregular menses	

When did you start to notice symptoms?

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Are these changing, increasing or decreasing?

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Have you noticed a connection between your symptoms and:

Diet	Work Load	Stress levels
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Do you use, or have you ever used hormone replacement therapy or bio-identical hormones?

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If so, which ones, and for how long?

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Thank you for taking the time to share your information.

Is there anything else you would like to tell me?

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