Client Name:_____

General Medical/Health History

How would you classify your general health: ☐ Good ☐ Fair ☐ Poor

In terms of your general health, please check ALL that apply:

☐ Alcohol/Drug Problems
☐ Allergies
☐ Anemia
☐ Asthma/Breathing Difficulties
☐ Cancer
Type:_____
☐ Change in Bowel/Bladder Function
☐ Chest Pain/Angina
☐ Concussions
☐ Depression
☐ Diabetes I or II
☐ Fibromyalgia
☐ Heart Attack
☐ Heart Disease
☐ Heart Palpitations
☐ Hepatitis
☐ Hernia
☐ High/Low Blood Pressure
☐ HIV
☐ Hypoglycemia
☐ Intolerance to cold/heat
☐ Jaw/Dental Issues
Explain:_____
☐ Kidney Problems
☐ Liver/Gallbladder problem
☐ Metal Implants
☐ Multiple sclerosis
☐ Night pain
☐ Numbness/Tingling
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Pain with Cough/Sneeze
☐ Physical Abnormalities
☐ Polio
☐ Recent Dizziness/Fainting
☐ Recent Headaches
☐ Recent Fever
☐ Recent Fractures
☐ Recent Nausea/vomiting
☐ Recent Unexplained Fatigue
☐ Recent Vision Changes
☐ Rheumatoid Arthritis
☐ Ringing in the ears
☐ Seizures/Epilepsy
☐ Skin Abnormalities
☐ Smoking History
☐ Stroke/TIA
☐ Surgeries
☐ Unexplained Weight Loss/Gain
☐ Vertigo/Vestibular Disorders
☐ Vision Changes
☐ Other
_____

Pelvic Medical/Health History

In terms of your pelvic health, please check ALL that apply (complete only if applicable for care):

☐ Coccyx Pain
☐ Constipation
☐ Currently Pregnant
☐ Diarrhea
☐ Endometriosis
☐ Erectile Dysfunction
☐ Fecal or Gas Incontinence
☐ IBS
☐ Painful Ejaculation
☐ Painful Periods
☐ Pelvic Pain
☐Physical or Sexual Abuse
☐ Prostate Disorders
☐ Sexual Dysfunction
☐ Sexually Transmitted Disease
☐ Shy Bladder
☐ Urine Leakage
☐ Vaginal Dryness

Menopause? ☐ Yes ☐ No If yes, date:_____

Date of Last Pelvic Exam:_____

Number of Pregnancies:_____

Number of Child Births:_____

Number of C-Sections:_____

Number of Vaginal Deliveries:_____

_____ _____

Signature *Date*