Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

Symptom Monitor

Thank you for taking the time to fill out this questionnaire. All answers are strictly confidential.

Name: _____ DOB: _____ Date: _____

Pronouns: _____ Occupation: _____

Presenting Problems: _____

_____

_____

When did this start? Is there an event that you associate with the onset of your symptoms?

_____

_____

What do you think is causing your symptoms? _____

_____

_____

Are you? ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner ☐ Single

Who lives in your home? _____

Who do you talk to about your issues?_____

Have you had any of the following medical procedures/surgeries?			
	Date		**Date**
Bartholin Cyst		Gallbladder	
Bowel Resection		Hemorrhoid Banding	
Lapatoscopy		Mesh Procedure	
Cystoscopy		Prolapse/Vaginal Repair	
Colostomy/Ileostomy		Hysterectomy	
Hernia Repair		Colonoscopy	
Appendectomy		TVT-TOT	
CT/MRI		X-Ray/Ultrasound	
Prostatectomy		TURP	
Radiation		Green Light Laser	
Chemotherapy		Brachyterapy	
Urolift		HIFU	
Vasectomy		Urodynamics	
Other:			

1519 – 19th Street NW, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403) 282-0898

Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

Gynaecological History	Answers	
At what age did you start your period?		
Is your cycle regular?	Yes	No
How many days does your period last?	1 2 3 4 5+	
Is your bleeding heavy?	Yes	No
Do you have any pain with your period? PMS? Cramps?	Yes	No
Do you use tampons or menstrual cups?	Yes	No
Do you have pain with insertion of a tampon or menstrual cup?	Yes	No
Do you have a lot of vaginal discharge?	Yes	No
Do you use birth control?	Yes	No
Are you sexually active?	Yes	No
Do you have pain with sexual activity?	Yes	No
Do you engage in penetrative intercourse?	Yes	No
Do you have pain with intercourse?	Yes	No
Do you have pain after intercourse?	Yes	No
Do you have pain at the opening of vagina with sexual activity?	Yes	No
Do you have deep pain in the vagina with sexual activity?	Yes	No
Do you participate in anal sex?	Yes	No
Do you have pain with anal penetration?	Yes	No
Are you physically intimate with your partner without penetration?	Yes	No
Do you use lubrication with sexual activity?	Yes	No
Are you currently pregnant?	Yes	No
Are you currently breast/chest feeding?	Yes	No
Have you had any miscarriages?	Yes	No
# Of pregnancies?	1 2 3 4+	
# Of C-sections?	1 2 3 4+	
# Of vaginal deliveries?	1 2 3 4+	
Weight of heaviest baby?		
Age of child(ren)?		
How long did you push during labour?	1 2 3 4+ (Hrs)	
Did you have an epidural?	Yes	No
Did you have a vacuum-assisted delivery? Forceps delivery?	Yes	No
Did you have episiotomies? Tearing? Grande?	Yes	No
Did you feel supported and cared for during labour?	Yes	No
Were there times during labour and delivery that you felt in danger?	Yes	No
Do you suffer/have you suffered from post-partum depression/anxiety?	Yes	No
Have you gone through menopause?	Yes	No
When was your last menstrul cycle?	Yes	No
Do you suffer from vaginal dryness?	Yes	No

1519 – 19th Street NW, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403) 282-0898

Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

Are you on any Hormone Replacement Therapy?	Yes	No
Do you use a vaginal moisturizer such Replens/Gynatrof/Repagyn?	Yes	No
Do you have feelings of heaviness/pressure in your vagina?	Yes	No
Do you physically feel something coming out of your vagina?	Yes	No
Have you ever been told you have a prolapse?	Yes	No
Do you have sensory changes/loss in your genitals?	Yes	No
Do you have a history of vulvar varicosities?	Yes	No

Fluid intake in a 24-hour period (approximately)	Cups/day
Number of cups of water per day	
Number of cups of other fluid/day (milk, juice, broth, soup)	
Number of cups of coffee/day	
Number of alcoholic drinks/day	
Number of cups of tea/day	
Number of carbonated drinks/day (pop, seltzer, carbonated water)	
Number of energy drinks/day	
Other:	

Bladder Symptoms	Answers		
Do you have a leakage with coughing, sneezing, laughing?	Yes	No	Sometimes
Do you leak with exercising, running, or jumping?	Yes	No	Sometimes
Do you have leakage during intercourse?	Yes	No	Sometimes
Do you feel a strong urge to void but do not leak?	Yes	No	Sometimes
Do you leak 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?	Yes	No	Sometimes
Do you have pain while voiding?	Yes	No	Sometimes
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 urinate?	Yes	No	Sometimes
Do you sit on the toilet to void?	Yes	No	Sometimes
Do you feel fully empty after you void?	Yes	No	Sometimes
Do you lose bladder control during the night?	Yes	No	Sometimes
Does your incontinence fluctuate during your cycle?	Yes	No	Sometimes
Do you wear pads? If so what kind:_____	Yes	No	Sometimes
How many pads do you wear during the day?	1 2 3 4 5+		
Do you go to the bathroom more than 8 times per day?	Yes	No	Sometimes
How many times do you wake during the night to void?	1 2 3 4 5+		

Digestion and Bowel Function	Answers
What is the frequency of your bowels? E.g. 1x/per day	

1519 – 19th Street NW, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403) 282-0898

Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

Do you regularly feel the urge to move your bowels?	Yes	No	Sometimes
Do you have constipation?	Yes	No	Sometimes
Do you strain to have a bowel movement?	Yes	No	Sometimes
Do you splint or assist to pass stool?	Yes	No	Sometimes
Do you use your finger to help evacuate stool?	Yes	No	Sometimes
Are you prone to having diarrhea/loose stool?	Yes	No	Sometimes
Do you have bowel urgency that is difficult to control?	Yes	No	Sometimes
Do you lose control of your bowels/accidental bowel leakage?	Yes	No	Sometimes
Do you have incomplete emptying after a bowel movement?	Yes	No	Sometimes
Do you have pain with a bowel movement?	Yes	No	Sometimes
Do you have pain *after* a bowel movement?	Yes	No	Sometimes
Does it take longer than 5 minutes to have a bowel movement?	Yes	No	Sometimes
Do you have abdominal cramps/pain?	Yes	No	Sometimes
Do you have bloating (increased pressure in abdomen)	Yes	No	Sometimes
Does your abdomen feel distended when your bowels are full?	Yes	No	Sometimes

In your opinion, is your fibre intake? ☐ Too low ☐ Adequate ☐ Too high

Do you regularly use? ☐ Laxatives ☐ Stool softener ☐ Natural Products ☐ Enemas

Have your bowel habits changed recently? This includes: ☐ Unexplained Weight Loss

☐ Abdominal Pain ☐ Rectal Bleeding ☐ Excessive Straining

Have you ever been diagnosed with/think you have:	Answers	
Irritable bowel syndrome	Yes	No
Ulcerative Colitis	Yes	No
Crohn's Disease	Yes	No
Celiac Disease	Yes	No

Do you have any allergies (gel/vinyl) or food sensitivities/allergies?

_____

Medical History	Answers		Notes
Urinary Tract Infections	Yes	No	
Recent antibiotics?	Yes	No	
Do you use probiotics?	Yes	No	
Do you use cranberry supplements?	Yes	No	
Do you smoke? Amount?	Yes	No	
Do you have a chronic cough?	Yes	No	
Do you get yeast infections?	Yes	No	
Do you get blood in your urine?	Yes	No	
Allergies?	Yes	No	What kind?
Do you exercise?	Yes	No	What type?

1519 – 19th Street NW, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403) 282-0898

Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

Low back problems?	Yes	No	
Mid back problems?	Yes	No	
Neck problems?	Yes	No	
Depression?	Yes	No	
Anxiety?	Yes	No	
Have you been diagnosed with a mental health condition?	Yes	No	

What physicians or health care providers have you seen for these problems?	
Physician/provider	Treatment provided?

Please list the medications you are currently taking (including vitamins and supplements)				
Medication/dose	Provider			

Is there anything else you would like to mention that might be important or relevant?

_____

_____

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

1519 – 19th Street NW, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403) 282-0898