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	_____	Urodyanmics	_____	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 steam?	☐ 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 <u>with</u> a bowel movement?	☐ Always	☐ Seldom	☐ Never
Do you have pain <u>after</u> 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
	Trigger point pain	No	Yes
Cardiovascular	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, o, 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

Patient name: _____ DOB: _____ Date: _____

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4