CENTER FOR
PELVIC HEALTH AND WELLNESS

Full Name:_____ Date of Birth :_____

Reason for visit today (Check all that apply):

□ Perimenopausal/Menopausal Health □ Sexual Health and Couple Wellness □ Hormone Balance - BioTe □ Create a Wellness Lifestyle □ Lose Weight	□ Vaginal Rejuvenation - ThermiVa □ Strengthening my CORE to FLOOR - Emsella □ Labial Issues □ Urinary/Bowel Issues □ Vaginal Laxity/Bulge □ Other _____

Please list your 3 major health goals in order of priority:

1. _____
2. _____
3. _____

Rate your Symptoms:

	Never	Mild	Mod	Severe		Never	Mild	Mod	Severe
Depressed mood	□	□	□	□	Decreased sex drive	□	□	□	□
Anxiety	□	□	□	□	Difficulty w/orgasm	□	□	□	□
Brain fog	□	□	□	□	Vaginal dryness	□	□	□	□
Memory loss	□	□	□	□	Painful intercourse	□	□	□	□
Sleep disturbance	□	□	□	□	Hot flashes	□	□	□	□
Irritability	□	□	□	□	Night sweats	□	□	□	□
Bloating	□	□	□	□	Dry/wrinkled skin	□	□	□	□
Weight gain	□	□	□	□	Loss of motivation	□	□	□	□
Breast tenderness	□	□	□	□	Loss of stamina	□	□	□	□
Hair falling out	□	□	□	□	Bladder issues	□	□	□	□
Cold intolerance	□	□	□	□	Headaches	□	□	□	□

Patterns Please mark frequency of activity per week:

Lift weights _____ Exercise _____ Get Outside _____

Skip Meals _____ Enjoy Work____ Sit at Computer _____

Sleep Well _____ Self Care _____ Nicotine _____

Meditate/Prayer ____ Intimacy _____ Move Bowels _____

Hydration What is your average daily intake? (oz)

Water _____ Caffeine ____ Alcohol ____ Soda _____

Juices _____ Milk _____ Energy Drinks____

Other _____

Fuel What % do you eat of the following daily?

Dairy % _____ Fats % _____ Vegetables % _____

Animal protein %_____Grains % _____

Fruit % _____ Processed foods % _____

Wellness Mark the wellness practices you use:

□ Acupuncture □ Chiropractic □ Physical Therapy

□ Yoga □ Massage □ Nutritional Counseling

□ Eye Care □ Exercise/Movement Classes

□ Psychological Services □ Supplements

□ Dental Care □ Regular Check-ups

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Past Dietary Changes Check all that apply, what, when?	**Past Treatments** Check all that apply, what, when?
□ Dietary changes	□ Diet Medications _____
□ Keto /Paleo	□ Diet Supplements _____
□ Anti-Inflammatory	□ Liposuction – Cool Sculpt
□ FODMAP	□ Tummy tuck – Breast Implants
□ Low Fat- Low Carb	□ Laser Vaginal Rejuvenation (Mona Lisa)
□ High Fiber	□ Radiofrequency Vaginal Rejuvenation (ThermiVa)
□ Low Residue	□ HIFEM (Emsculpt or Emsella)
□ Vegan or Plant Based	□ BioTe or Sotopelle Hormone Pellets
□ Mediterranean	□ Bio-identical Hormone Therapy _____
□ Weight Watchers	□ Vaginal Hormones _____
□ V-Shred	□ Lubricants _____
□ Beach Body	□ OShot or PRP
□ Intermittent Fasting, Type _____	□ Pelvic Physical Therapy
□ Other _____	□ Vibrators or Dilators _____
	□ Couples or Individual Therapy
	□ Botox or Fillers _____
	□ Skin Care _____
	□ Other _____

Other Wellness or Sexual Concerns