



CENTER FOR
PELVIC HEALTH AND WELLNESS

Full Name: _____ Date of Birth : _____

Reason for visit today (Check all that apply):

<input type="checkbox"/> Perimenopausal/Menopausal Health <input type="checkbox"/> Sexual Health and Couple Wellness <input type="checkbox"/> Hormone Balance - BioTe <input type="checkbox"/> Create a Wellness Lifestyle <input type="checkbox"/> Lose Weight <input type="checkbox"/> Sculpt/Tone Body- Emsculpt or Emtone	<input type="checkbox"/> Vaginal Rejuvenation - ThermiVa <input type="checkbox"/> Strengthening my CORE to FLOOR - Emsella <input type="checkbox"/> Labial Issues <input type="checkbox"/> Urinary/Bowel Issues <input type="checkbox"/> Vaginal Laxity/Bulge <input type="checkbox"/> Other _____
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Please list your 3 major health and wellness goals in order of priority:

1. _____
2. _____
3. _____

Rate your Symptoms:

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

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:	
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Yoga	<input type="checkbox"/> Massage	<input type="checkbox"/> Nutritional Counseling
<input type="checkbox"/> Eye Care	<input type="checkbox"/> Exercise/Movement Classes	
<input type="checkbox"/> Psychological Services	<input type="checkbox"/> Supplements	
<input type="checkbox"/> Dental Care	<input type="checkbox"/> Regular Check-ups	



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Past Dietary Changes Check all that apply, what, when?	Past Treatments Check all that apply, what, when?
<ul style="list-style-type: none"><input type="checkbox"/> Dietary changes<input type="checkbox"/> Keto /Paleo<input type="checkbox"/> Anti-Inflammatory<input type="checkbox"/> FODMAP<input type="checkbox"/> Low Fat- Low Carb<input type="checkbox"/> High Fiber<input type="checkbox"/> Low Residue<input type="checkbox"/> Vegan or Plant Based<input type="checkbox"/> Mediterranean<input type="checkbox"/> Weight Watchers<input type="checkbox"/> V-Shred<input type="checkbox"/> Beach Body<input type="checkbox"/> Intermittent Fasting, Type _____<input type="checkbox"/> Other _____	<ul style="list-style-type: none"><input type="checkbox"/> Diet Medications _____<input type="checkbox"/> Diet Supplements _____<input type="checkbox"/> Liposuction – Cool Sculpt<input type="checkbox"/> Tummy tuck – Breast Implants<input type="checkbox"/> Laser Vaginal Rejuvenation (Mona Lisa)<input type="checkbox"/> Radiofrequency Vaginal Rejuvenation (ThermiVa)<input type="checkbox"/> HIFEM (Emsculpt, Emtone, or Emsella)<input type="checkbox"/> BioTe or Sotopelle Hormone Pellets<input type="checkbox"/> Bio-identical Hormone Therapy _____<input type="checkbox"/> Vaginal Hormones _____<input type="checkbox"/> Lubricants _____<input type="checkbox"/> OShot or PRP<input type="checkbox"/> Pelvic Physical Therapy<input type="checkbox"/> Vibrators or Dilators _____<input type="checkbox"/> Couples or Individual Therapy<input type="checkbox"/> Botox or Fillers _____<input type="checkbox"/> Skin Care _____<input type="checkbox"/> Other _____

Other Wellness or Sexual Concerns