Your Health Story

ABDOMINAL THERAPY COLLECTIVE

Please fill out this questionnaire to the best of your ability. Some of the questions may feel challenging to answer or may seem unrelated to your primary issue. The goal of this health story is to look at you and your life experiences holistically, compassionately and as a tool for education.

Name

Address

Phone

Email

Date of birth

Preferred pronoun

Gender currently identifying as

Gender assigned at birth

How did you hear about me and this work?

Abdominal Therapy is not a substitute for care by your medical doctor. Abdominal Therapy practitioners do not diagnose medical diseases, physical or mental conditions. Abdominal Therapy practitioners do not prescribe medical pharmaceuticals.

COVID19 Screening

Have you tested positive or had treatment for Covid-19? ☐ Yes ☐ No

If yes, when was your test?

Have you tested negative since this time? ☐ Yes ☐ No

Have you been following social distancing measures? ☐ Yes ☐ No

Do you or have you recently had a fever? ☐ Yes ☐ No

Have you, or has anyone you are in close contact with had any of the following signs or symptoms associated with Covid-19:

- ☐ Fever
- ☐ Chills
- ☐ Pink eye
- ☐ Muscle ache
- ☐ Sore throat
- ☐ Persistent dry cough
- ☐ Runny nose
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Headache
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Loss of smell & taste
- ☐ Long-term chesty cough producing mucus

I have stated all known conditions and will keep my practitioner updated on my health. By signing below, I confirm all the information I've provided is correct. I understand this information will remain confidential.

Signature

Name

Date

What's the reason for your visit?

Primary reason for this visit?

What would you like to achieve as a result of your visit?

When did you first notice this?

Do you feel something may have triggered this?

Describe any stressors occurring at this time?

What makes you feel better?

What makes you feel worse?

What changes or goals would you like to achieve over the next 3/6 months?

A Little bit of History

Are you taking any of the following – medication, supplementation, natural remedies?
If so, please give details:

Do you use alcohol or recreational drugs? If so, how regularly and how do you feel about this?

Do you smoke? If so, how regularly and how do you feel about this?

Any allergies? If yes, what are you allergic to? What reaction do you have?

Have you experienced any of the following? If so, please share some details.

Surgery

Accidents

Injuries to sacrum/head/tailbone

Concerns

Do you, or have you ever suffered from any of the following:

- ☐ Headache
- ☐ Asthma
- ☐ Cold hands/feet
- ☐ Swollen ankles
- ☐ Sinus conditions/colds
- ☐ Seizures
- ☐ Skin conditions
- ☐ Lower back pain
- ☐ Sciatica
- ☐ Herniated/bulging discs
- ☐ Painful/swollen joints
- ☐ Neck/shoulder/jaw tension
- ☐ High/low blood pressure
- ☐ Sore heels when walking
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep disturbance
- ☐ Feeling faint
- ☐ Varicose veins
- ☐ Cancer (type)
- ☐ Haemorrhoids
- ☐ Numb feet on standing

Family Story

Please share any significant details of your birth family story if known; this may include physical or mental health, lifestyle, cause/age of death of your parents and any other details you feel are relevant.

Maternal

Paternal

Gut Health

Describe your relationship with food?

What were mealtimes like growing up?

What are mealtimes like now?

Do you have any food intolerances or allergies?

Do you follow a particular diet?

Do you eat home cooked food? ☐ Mainly ☐ Occasionally ☐ Never

What is your typical daily intake of the following?

Water Caffeine Alcohol

Do you experience any bloating, burbs or flatulence after eating? ☐ Yes ☐ No

If so, what triggers this?

How often are your bowel movements?

Do you suffer from abdominal pain, constipation, diarrhea, incomplete bowel movements, thin stools, blood or mucus in your stools?

Mental & Emotional Health

How do you nurture yourself?

Where and how do you find joy?

Are you currently experiencing stress?

How do these affect your life and how do you manage them?

Do you have a faith or spiritual practice and if so, would you be willing to share this?

What exercise do you enjoy, and how often do you do it?

Do you experience low mood, anxiety, depression, post-traumatic stress disorder, or any other mental health condition that you are willing to share?

Have you experienced any traumatic events that you would be willing to share?

Have you considered seeking professional support?

Pelvic Health

Do you experience pelvic pain or congestion? ☐ Yes ☐ No

If so, how does this affect you?

Do you experience pain in any of the following areas?

- ☐ Uterus
- ☐ Ovaries
- ☐ Vagina
- ☐ Vulva
- ☐ Penis
- ☐ Prostate
- ☐ Testicles
- ☐ Rectum
- ☐ Pain during sex
- ☐ Perineum

Do you experience any of the following urinary issues? If so, how does this affect you?

- ☐ Incontinence – coughing, jumping
- ☐ Overactive bladder
- ☐ Night time urgency
- ☐ Cystitis
- ☐ Incomplete bladder emptying
- ☐ Constant leakage
- ☐ Interstitial Cystitis
- ☐ Kidney Stones
- ☐ Bladder cancer
- ☐ Bladder prolapse
- ☐ Bladder stones

Have you had any pelvic tests – PAP, PSA or STD?

Have you ever had abnormal results? ☐ Yes ☐ No

If so when, and did you receive treatment?

Do you currently/have you use/used birth control? If so, please indicate which one and if hormonal, how long for:

- ☐ Pill
- ☐ Patch
- ☐ Diaphragm
- ☐ Injection
- ☐ Condoms
- ☐ IUD
- ☐ Abstinence
- ☐ Rhythm Method

Menstrual Health

Do you experience any of the following:

- ☐ Painful periods
- ☐ Absent period
- ☐ Lower back pain before/ during/after bleeding
- ☐ Irregular cycles
- ☐ Heaviness prior to period
- ☐ Dark thick blood – start/end
- ☐ Excessive bleeding
- ☐ Clots
- ☐ Dizziness
- ☐ Bowel changes
- ☐ Headache/migraine
- ☐ Water retention
- ☐ Endometriosis
- ☐ Painful ovulation
- ☐ Irregular ovulation
- ☐ Lack of ovulation
- ☐ Bleeding/spotting during ovulation
- ☐ Premature Ovarian Failure
- ☐ Polyps – uterine/cervical
- ☐ Fibroids – location/size/number
- ☐ Cysts – location/size/number
- ☐ Incontinence- bladder/bowel
- ☐ Vaginal dryness
- ☐ Bloating

How old were you when you started menstruating?

What was this like for you?

How many days is your menstrual cycle?

How many days is your bleed?

Please include number of days spotting at beginning or end.

What menstrual products do you use?

Do you bleed through more than one tampon or pad per hour?

When was your last menstrual bleed?

How do you feel about your menstrual cycle?

Do you Chart your cycle?

If so how – App, Paper charts?

Do you know if your mother, sister or other close female relations have experienced any of the following issues?

- ☐ Infertility
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Cancer
- ☐ Menstrual issues
- ☐ Menopause issues

Urogenital Health

Do you experience or have a history of any of the following:

- ☐ Painful/burning on urination
- ☐ Urinary retention
- ☐ Urinary incontinence or dribbling
- ☐ Difficult to start urination
- ☐ Weak/interrupted urine flow
- ☐ Frequent bladder infections
- ☐ Blood/pus in urine
- ☐ Pelvic pain/pressure
- ☐ Night time urination
- ☐ Pain/discomfort in -
- ☐ Testicles
- ☐ Penis
- ☐ Rectum
- ☐ Inner Thigh
- ☐ Pelvic Floor/perineum
- ☐ Erection pain/problems
- ☐ Lower back pain especially after sex
- ☐ Changes in sex drive
- ☐ Prostate disease or cancer
- ☐ Pelvic injury or surgery
- ☐ Sperm related fertility issues
- ☐ Vulvodynia
- ☐ Cystitis
- ☐ Interstitial cystitis
- ☐ Herpes
- ☐ HPV
- ☐ Bartholomew Cysts

Desire & Libido

Do you enjoy making love?

Do you climax?

Are you satisfied with your level of sexual desire?

Have you noticed any changes recently?

How do you feel about this?

Fertility & Pregnancy Health

Are you hoping to conceive?

If so, how long have you been trying?

Have you or your partner had any pregnancies? ☐ Yes ☐ No

If so, did you choose to continue with them and what were they like?

Have you experienced any loss?

Have you given or witnessed birth?

If so what was the experience like?

How was your postpartum experience?

Have you had any fertility tests e.g. Sperm or egg reserve?

Are you under the care of a fertility specialist?

Please describe any treatment you may have received including - IUI, IVF, ICSI, Hormone treatment or Surgery.

Peri/Menopause Health

How do you feel about your menopausal journey?

What stories do you carry?

What positive menopausal role models do you have?

Are you keeping your menopausal journal?

Do you experience any of the following:

- ☐ Hot flushes
- ☐ Vaginal discharge
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Painful sex
- ☐ Insomnia
- ☐ Dry/itchy skin
- ☐ Dry/itchy vagina
- ☐ Vaginal Atrophy
- ☐ Spotting
- ☐ Flooding
- ☐ Tiredness
- ☐ Depression
- ☐ Anxiety
- ☐ Irregular menses
- ☐ Poor memory
- ☐ Mood swings
- ☐ Irritability

When did you start to notice symptoms?

Are these changing, increasing or decreasing?

Have you noticed a connection between your symptoms and:

- ☐ Diet
- ☐ Work Load
- ☐ Stress levels

Do you use, or have you ever used hormone replacement therapy or bio-identical hormones?

If so, which ones, and for how long?

Thank you for taking the time to share your information.

Is there anything else you would like to tell me?