a natural approach to the roots of your health

LITTLE OAK wellness

Hello,
Thank you for choosing Little Oak Wellness for your rehabilitation needs! We are excited to meet you at your first appointment!

It sometimes feels like there is a lot of information to go through in the first session. We will give you ample time to tell your story and express your concerns and goals for wellness.

Attached to this email is a questionnaire to help you tell your story! We have designed this questionnaire based on the most up-to-date research on the contributing factors of pain and pelvic health.

Completing this questionnaire helps me look at every problem from a whole-person perspective. This will allow me to look at your issue(s) from all angles and increases the efficiency and effectiveness of our work together. Your pain, pelvic health, and symptoms may arise from many different social, emotional, and physical factors.

Some have reported that it feels overwhelming to fill out the questionnaire since it does cover your life story and symptoms in detail. Rest assured; completion of the questionnaire is completely voluntary. If you do not complete it due to your comfort level, it will not affect the quality of care that you receive. Please answer only the questions you are comfortable with.

If you have any personal questions you would like to address before your first appointment, please feel free to email me personally at sam@littleoakwellness.ca.

Thank you for partnering with us on your journey towards better health!

-Samantha Del Bigio (MPT, B.Sc, Licenced in Pelvic Floor Physiotherapy)

Pelvic Floor Intake Form - Male

Name: _____ Age: _____ Date: _____

Presenting problems/when did this start?_____
_____

Have you ever seen a physician or healthcare provider for the problem you are coming in for today? Yes No If yes, who? _____

Treatment provided?_____

Occupation: _____ Referral/Source:_____

Diagnosis/Reports:_____

Hobbies/activities:_____

Prostate/Penile Health- Please complete the following sections if they apply to you & you are comfortable answering:

Last PSA score: _____ When? _____

Last digital rectal exam? _____

Does your prostate get painful/irritated? No Yes

Has your prostate fluid been expressed or tested? No Yes

Do you have painful erections? No Yes

Can you achieve a satisfactory erection? No Yes

Do you have pain with ejaculation? No Yes

Do you have pain during intercourse? No Yes When? _____

Do you participate in anal sex? No Yes Sometimes

Do you have pain with anal penetration? No Yes Sometimes

Have you had any of the following procedures? If so, please provide the approximate date:

Appendectomy _____ Laparascopy _____ TVT-TVT(O) _____

Mesh procedure _____ Colostomy _____ Hernia repair _____

Bartholin Cyst _____ Cystoscopy _____ Gallbladder removal _____

Prolapse repair _____ Vasectomy _____ Urodynamics _____

Bowel resection _____ Colonoscopy _____ Hemorrhoid surgery _____

Hysterectomy _____ Prostatectomy _____ Other_____

Bladder Symptoms

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 ever feel a strong urge to void but don't leak? Yes No Sometimes

Do you ever rush to the toilet when you feel a strong urge? Yes No Sometimes
If yes, how often? _____

Do you sometimes not make it to the toilet? Yes No Sometimes
If yes, how often?_____

What triggers brings on the urgency? Washing hands? Hearing water run?
Drinking liquid? "Key in door"?
Other?_____

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 when you void? 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 get up from the toilet? Yes No Sometimes

Do you sit on the toilet? Yes No Sometimes

Do you have incomplete emptying when you void and feel like you have to go again soon? Yes No Sometimes

Does your bladder problems cause you to leak at night? Yes No Sometimes

Does your incontinence require you to wear pads? Yes No Sometimes
If yes or sometimes, how often/which type? _____

Do you void during the day more than the average person? Yes No Sometimes
(5-7 times per day?) If yes or sometimes, how often? _____

Do you need to get up at night to void? Yes No Sometimes
If yes or sometimes, how many times? _____

Fluid Intake in 24 hours

cups of water per day: _____ # cups of coffee per day: _____ # cups of tea per day: _____ # cups of other fluids per day: _____ # alcoholic drinks: _____ /day/week/month

Digestion and Bowel Function

What is the frequency of your bowel movements? _____

Do you regularly feel the urge to move your bowels?	Always	Sometimes	Never
Do you have control over your bowels to make it to the toilet?	Always	Sometimes	Never
Do you have constipation?	Always	Sometimes	Never
Do you strain to have a bowel movement?	Always	Sometimes	Never
Do you splint or assist to pass stool?	Always	Sometimes	Never
Do you have loose stools/diarrhea?	Always	Sometimes	Never
Do you have incomplete emptying?	Always	Sometimes	Never
Do you have pain <u>with</u> a bowel movement?	Always	Sometimes	Never
Do you have pain <u>after</u> a bowel movement?	Always	Sometimes	Never
Does it take longer than 5 minutes to have a bowel movement?	Always	Sometimes	Never
Do you have bloating (increased pressure in the abdomen)?	Always	Sometimes	Never
Do you experience a physical change in abdominal girth when your bowels are full (distension)?	Always	Sometimes	Never
Do you have blood in your stool?	Always	Sometimes	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 or think you have:

Irritable bowel syndrome	When? _____
Ulcerative colitis	When? _____
Crohn's disease	When? _____
Celiac disease	When? _____

Medical History

Urinary tract infections? Yes No How often? _____ Last infection? _____

Yeast infections? Yes No How often? _____ Last infection? _____

Antibiotics recently? Yes No Last dose? _____ Probiotics? Yes No

Cranberry supplementation? Yes No Do you smoke? Yes No #_____ packs/day

Chronic cough? Yes No Do you get blood in your urine? Yes No

Do you have any food allergies or sensitivities?_____
_____

Other Allergies (including latex):_____

Do you exercise? Yes No 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
If yes, what treatment? _____ Is/was treatment effective? Yes No

Have you ever been treated for anxiety? Yes No
If yes, what treatment? _____ Is/was treatment effective? Yes No

Have you ever been diagnosed with a mental health condition? Yes No
If yes, what? _____

Do you have any other medical conditions? Check any that apply:

Arthritis ___	Heart attack ____	Diabetes_____
Osteoporosis ___	Pacemaker_____	Thyroid problems___
Scoliosis ___	Angina_____	Glandular problems____
Other bone/joint issues ___	High blood pressure_____	Skin conditions____
Muscular disorder ___	Low blood pressure _____	Disease of internal organs__
Stroke ___	Other heart problems_____	Cancer____
Epilepsy _____	Breathing disorders_____	X-ray therapy____
Multiple Sclerosis _____	Dizziness_____	High dose steroid therapy___
Other neurological disorders ____	Fainting_____	Varicose veins _____

Previous fractures, surgeries, or hospitalizations: _____
_____

Please list all medications you are currently taking (including vitamins/supplements):
_____