Holistic Pelvic CareTM —Client Intake Form

Contact Information:

Name_____

Date of Birth: __/___/___

Today's Date: ___/___/___

Primary Care Provider (Midwife or Doctor):

_____

Source of Referral: _____

Home Address:

_____

Home Phone: _____

Cell Phone: _____

Email: _____

Subjective History:

What is the primary reason for your visit today/your major concern?

_____

When and how did this begin?

Have you received any other treatments or tests for this concern?

What are your goals for treatment today?

Please list any other pertinent medical diagnoses/treatments:

Medical History:

Date of last pelvic exam/PAP:
_____Results:
_____

Any past positive PAP?

_____

Birth History:

Of pregnancies_____

of births_____

Date/Type of birth (vaginal/cesarean)

_____
_____

Please list any pelvic or abdominal surgeries:

Please list types of birth control used/length of time utilized:

If you have now, or had in the past any of the following, please check and explain with dates:

_____Low back pain:

_____Pelvic/Abdominal pain

_____Menstrual Pain/PMS

_____ Prolonged Bleeding/Altered Cycles

_____Pain During Sex

_____ Sexually Transmitted Diseases

_____Fibroids/Cysts

_____UTI/Bladder Infections

_____Hemorrhoids

____ Constipation/Irritable Bowel

_____Tearing with birth

_____Pregnancy/Childbirth Complications

_____Sexual Abuse

_____Physical/Other Abuse

_____Depression

_____Cancer

_____Drug Abuse

_____Smoking Habit

_____Eating Disorder

_____Other relevant info