New Client intake form

LET'S GET STARTED!

Client's name _____ Date _____

Date of birth _____ Gender _____

Phone (C) _____ Phone (H) _____

Email _____

Emergency Contact _____ Relationship to client _____

Phone (C) _____ Phone (H) (W) _____

Relationship status: circle and/or explain

- married / committed relationship / dating / single / widowed / other

Occupation:

Lifestyle:

- Days of exercise per week: 5-7 3-5 1-2 0
- Average fluid intake/day (and types of drinks):
- Sleep problems: trouble falling asleep / staying asleep / other
- What things are stressors in your life?

Past Medical History: check all that apply

☐ high blood pressure	☐ osteoporosis	☐ thyroid condition
☐ diabetes	☐ cancer	☐ circulation disease
☐ heart disease	☐ arthritis	☐ infection disease
☐ breathing problems	☐ currently pregnant	☐ other, explain below

Surgeries outside of pelvic area:

Current medications / reasons for taking them:

Allergies:

Obstetric History: please list # of:

_____ total pregnancies _____ vaginal deliveries _____ episiotomies

_____ live births _____ cesareans _____ vaginal tears

Gynecologic History:

Do you have menstrual periods? Y / N

Do you have regular menstrual periods? Y / N

Do you have pain with your menstrual periods? Y / N

Are you on hormone replacement therapy? Y / N

Do you have (check all that apply):

☐ endometriosis ☐ cystocele ☐ pelvic pain (not during sex)

☐ ovarian cysts ☐ rectocele ☐ low back pain

☐ fibroids ☐ vaginal prolapse ☐ other:

Bowel History: Have you had any of these problem now or in the past?

Regular use of laxatives: Y / N

Fecal incontinence episodes: Y / N How often?

How often do you have bowel movements?

Bladder History:

How many times a day do you urinate?

Do you strain to empty your bladder? Y / N

Do you have any trouble starting your stream? Y / N

Are you able to completely empty your bladder? Y / N

Do you have pain with urination? Y / N

Do you have urinary incontinence: Y / N How often?

Do you leak with any of these? (check all that apply):

☐ coughing ☐ lifting ☐ strong urge without reason

☐ laughing ☐ bending ☐ other:

☐ sneezing ☐ sex

How many pads a day do you use for urinary incontinence?

Pelvic and Sexual History: This gets really personal but answering these questions ahead of time will make our first conversation much easier, promise. :-)

Pelvic surgeries (with dates/years):

Are you able to have vaginal sex now? Y / N

If not, have you ever been able to to have vaginal sex? Y / N

When did you first have pain with sex (or attempted sex)?

How would you describe your pain with sex (or attempted sex if unable):
When does it occur?

Describe your pain and when it occurs.

Do you have pain every time you have sex?

On a scale of 0-10, (10 being the worst) how intense is your pain?

What makes your pain better?

What makes your pain worse?

Do you have pain the next day? Y / N

On a scale of 0-10, (10 being the worst) how distressing is your pain with sex?

Do you attribute your pain to any particular event or feeling? (ex. child birth, assault, accident, fall, stress, depression)

What are your goals for your sex life? (I can help you work through this when we meet)

Is there anything else that you want to tell me before we meet?

Please make sure you email this to me at **hello@drlaurencrigler.com** at least 24-48 hrs before our appointment time. I will thoroughly review it before we meet. I can't wait to see you and get started on solutions!