



## Health History Form

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 history form is to look at you and your life experience holistically.

Name

Address

Phone

Email

Date of birth

Gender assigned at birth

Preferred pronoun

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

Have you been following social distancing measures?      Yes      No

Do you have a temperature?      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                | Runny nose          | Abdominal pain                         |
| Chills               | Wheezing            | Diarrhoea                              |
| Pink eye             | Shortness of breath | Loss of smell & taste                  |
| Muscle ache          | Chest pain          | Long-term chesty cough producing mucus |
| Sore throat          | Headache            |  |
| Persistent dry cough | Nausea/vomiting     |  |

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 would you like to achieve over the next 6 months?

## A Little bit of History

Are you currently under the care of any other health care provider?

Are you taking any of the following - medication, contraception, 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 so to what and how do you react?

Have you experienced any of the following? If so, what was it for and when?

Surgery

Accidents

Injuries to sacrum/head/taillbone

## 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.

Maternal

Paternal

## Gut Health

What is your relationship with food like?

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, diarrhoea, 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?

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 significant traumatic events in your life that you are willing to share?

Have considered seeking professional support?

## Pelvic Health

Do you experience pelvic pain or congestion? If so, how does this affect you?

Do you experience pain in any of the following areas?

Uterus

Ovaries

Vagina

Vulva

Penis

Prostate

Testicles

Perineum

Rectum

Pain during sex

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

Incontinence while  
coughing or jumping

Incomplete bladder  
emptying

Bladder cancer  
Bladder prolapse

Overactive bladder

Constant leakage

Bladder stones

Night time urgency

Interstitial Cystitis

Cystitis

Kidney Stones

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

Have you ever had abnormal results?

If so when, and did you receive treatment.

Do you use birth control? If so, please indicate which:

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

Have you ever used hormonal contraception in the past? If so, for how long and when?

## Menstrual Health

Do you suffer from any of the following:

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

Do you suffer from recurring or frequent infections of the bladder, uterine, vagina - bacterial or yeast?

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, including the days of 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, what method do you use (App or paper charts)?

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

Infertility  
Fibroids

Endometriosis  
Cancer

Menstrual issues  
Menopause issues

## Urogenital Health

Do you suffer 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

Have you had any prostate or sperm health tests? If so, please share results.

## Desire & Libido

Do you enjoy making love?

Do you achieve climax?

Are you satisfied with your level of sexual desire?

Have you noticed any changes recently? If so, how do you feel about this?

## Fertility & Pregnancy Health

Are you hoping to conceive? If so, how long have you been trying?

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

Have you suffered any loss?

Have you given birth? If so, what was this like?

How was your postpartum experience?

Have you had any fertility tests?

Are you under the care of a fertility specialist?

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

## Menopause Health

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 any of the following:

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?

How do you feel about this time of change?

Do you know the age of your mother or other close female relatives at menopause?

Thank you for taking the time to share your information.

Is there anything else you would like to share?