Your Health Story

ABDOMINAL THERAPY COLLECTIVE

Please fill out this questionnaire to the best of your ability. Answer only those questions with which you are comfortable.

The goal of Your Health Story is to look at you and your life experiences holistically, compassionately, and as a tool for your education.

Name

Address

Phone

Email

Date of birth

Would you care to share your pronouns?

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. Abdominal Therapy practitioners do not prescribe medical pharmaceuticals.

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?

COVID-19 Information

Have you had Covid-19? ☐ Yes ☐ No

If so, when?

Are you vaccinated against Covid-19? ☐ Yes ☐ No

Do you have any symptoms in connection with the vaccination or the infection? ☐ Yes ☐ No

If yes, can you describe these?

A Little Bit of Your Story

Are you taking any of the following – medication, supplementation, natural remedies, hormone therapy?
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?

Are you allergic to anything? If so, 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

Have you ever experienced any of the following? If so, please indicate which apply to you:

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

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 sensitivities, 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, burps, 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 does your stress affect your life, and how do you manage that?

Do you have a 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 anything else you would like to share?

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

Have you considered seeking professional support relating to any of the above? ☐ Yes ☐ No

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? If so, please indicate which apply to you:

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

Do you experience any of the following urinary issues? If so, please indicate which apply to you:

Incontinence:
- ☐ when coughing or jumping

Urinary urgency:
- ☐ Night-time
- ☐ Daytime
- ☐ Incomplete emptying of your bladder
- ☐ Constant urinary leakage
- ☐ Cystitis
- ☐ Interstitial Cystitis
- ☐ Kidney Stones
- ☐ Bladder cancer
- ☐ Bladder prolapse
- ☐ Bladder stones

If you have indicated any urinary issues, how does this affect you?

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

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

Urogenital Health

Have you ever experienced any of the following? If so, please indicate which apply to you:

- ☐ Pain/burning on urination
- ☐ Urinary retention
- ☐ Urinary incontinence/dribbling
- ☐ Difficulty to start urination
- ☐ Weak/interrupted urine flow
- ☐ Frequent bladder infections
- ☐ Blood/discharge 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

- ☐ Prostate disease or cancer
- ☐ Pelvic injury or surgery
- ☐ Sperm related fertility issues
- ☐ Vulvodynia
- ☐ Herpes
- ☐ HPV
- ☐ Bartholin's Cyst
- ☐ Changes in libido
- ☐ Yeast infection

Menstrual Health

Have you ever experienced any of the following? If so, please indicate which apply to you:

- ☐ Painful period
- ☐ Absent period
- ☐ Scanty period
- ☐ Lower back pain:- before/during/after bleeding
- ☐ Irregular cycles
- ☐ Heaviness prior to period
- ☐ Dark thick blood at start/end
- ☐ Excessive bleeding
- ☐ Clots
- ☐ Endometriosis
- ☐ PMS

- ☐ Headache/migraine
- ☐ Dizziness
- ☐ Bowel changes
- ☐ Bloating
- ☐ Water retention
- ☐ Painful ovulation
- ☐ Irregular ovulation
- ☐ Lack of ovulation
- ☐ Vaginal dryness
- ☐ Bleeding/spotting during ovulation
- ☐ Premature Ovarian Failure

- ☐ Polyps: uterine/cervical ☐ ☐
- ☐ Incontinence: bladder/bowel ☐ ☐
- ☐ Fibroids: location/size/number
- ☐ Cysts: location/size/number

How old were you when you started menstruating? What was this like for you?

How do you experience menstruation today?

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?

What date was the beginning of your last menstrual bleed?

How do you feel about your menstrual cycle?

Do you chart your cycle? ☐ Yes ☐ No

If so how – App, paper charts, other?

Do you know if your mother, sister, or other close female relations have experienced any of the following issues? If so, please indicate who this relates to:

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

Desire & Libido

Do you enjoy sex?

Are you able to reach orgasm?

Are you satisfied with your libido?

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?

Are you under the care of a fertility specialist?

Please describe any treatment you may have had, or are currently receiving

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 a menopausal journal? ☐ Yes ☐ No

Do you experience any of the following? If so, please indicate:

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

When did you start to notice symptoms?

Are these changing, increasing, or decreasing?

Have you noticed a connection between your symptoms and:

Diet Workload 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 Health Story.

Is there anything else you would like to tell me?