**Name: Date:**

**What pronouns do you prefer that we use when talking about you? (check all that apply)**

☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your current gender identity? (Check ALL that apply)**

☐ Male ☐ Female

☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer

☐ Additional category (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Decline to answer

**What sex were you assigned at birth? (Check one)**

☐Male ☐ Female ☐ Other ☐ Decline to answer

**Check OTHER current symptoms you are experiencing:**

\_\_\_\_Fatigue Weakness \_\_\_\_ Fever/Chills/Sweats \_\_\_\_ Interrupted Sleep

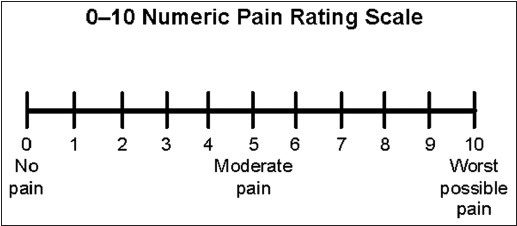
\_\_\_\_ Weight Loss/Gain \_\_\_\_Night Pain/Sweats \_\_\_\_ Numbness/Tingling

\_\_\_\_ Nausea/Vomiting \_\_\_\_ OTHER (Describe):

**Please explain the problem more and tell when you first noticed the problem.**

**How has it changed in the past year?** \_\_\_\_\_Same \_\_\_\_\_Worse \_\_\_\_\_Better

**Check Your Pain Level:**



**Describe Pain:**

**\_\_\_\_\_**None\_\_\_\_\_Constant Burning \_\_\_\_\_Intermittent Ache \_\_\_\_\_Other

Describe:

**Please list SPECIALISTs you have seen (Neurologist, Psychologist/Psychiatrist, Urologist, etc.**)

DATE LOCATION SPECIALIST RESULTS

**Please list Diagnostic TESTS (i.e. urinalysis performed, treatments given, & exercises done for current problem):**

DATE LOCATION Diagnostic Tests/Treatments/Exercises RESULTS

**Check the following conditions you are experiencing or have experienced:**

\_\_\_Acid Reflux/Belching

\_\_\_Alcohol/Drug Addiction

\_\_\_Ankle Swelling

\_\_\_Anorexia/Bulimia

\_\_\_Childhood Bladder Problems

\_\_\_Chronic Fatigue Syndrome

\_\_\_Endometriosis

\_\_\_Fibromyalgia

\_\_\_Head Injury

\_\_\_Headaches

\_\_\_Hearing/Vision Loss

\_\_\_Irritable Bowel Syndrome

\_\_\_Joint Replacement

\_\_\_Latex Sensitivity

\_\_\_Low Back Pain

\_\_\_Osteoporosis

\_\_\_Pelvic Pain

\_\_\_Physical/Sexual Abuse

\_\_\_Sacroiliac/Tailbone pain

\_\_\_Smoking History

\_\_\_Sports Injury

\_\_\_Stress Fracture

\_\_\_TMJ Neck Pain

\_\_\_Other

**Please list any hospitalizations, injuries, and other chronic or severe illness you have experienced:**

DATE HOSPITALIZATIONS/INJURIES/SURGERIES/OTHER REASON

**Please list all PRESCRIPTION (Rx) and OVER THE COUNTER (OTC) medications that you are currently taking (Include all injectable, oral, rectal, and topical MEDICATIONS**):

**Check and Complete all activities/events that cause or aggravate your symptoms**:

\_\_\_\_Changing positions (i.e., sit to stand) \_\_\_\_Light activity/housework

\_\_\_\_No activity affects \_\_\_\_Sitting greater than \_\_\_minutes

\_\_\_\_Standing greater than \_\_\_minutes \_\_\_\_Sexual activity:

\_\_\_\_With cold weather: \_\_\_\_Vigorous activity/exercise (run/weight lift/jump)

\_\_\_\_Walking greater than \_\_\_minutes \_\_\_\_With cough/sneeze/straining

\_\_\_\_With laughing/yelling; \_\_\_\_With lifting/bending

\_\_\_\_With triggers (i.e. key in door) \_\_\_\_With nervousness/anxiety

\_\_\_\_Other (Describe):

**Complete:** Ways you use to relieve your symptoms

**Mental Health:** 1) \_\_\_Happy; 2) \_\_\_Low stress; 3) \_\_\_Mod stress: 4) \_\_\_High stress; 5) \_\_\_Other

**Fluid Intake:**

Water drinking: \_\_\_\_None \_\_\_\_1-3 glasses per day \_\_\_\_4-6 glasses per day \_\_\_\_7 or more glasses per day

Fruit juice: \_\_\_\_None \_\_\_\_1-3 glasses per day \_\_\_\_4-6 glasses per day \_\_\_\_7 or more glasses per day

Caffeinated: \_\_\_\_None \_\_\_\_1-3 glasses per day \_\_\_\_4-6 glasses per day \_\_\_\_7 or more glasses per day

Soda: ­\_\_\_\_None \_\_\_\_1-3 glasses per day \_\_\_\_4-6 glasses per day \_\_\_\_7 or more glasses per day

Other: \_\_\_\_None \_\_\_\_1-3 glasses per day \_\_\_\_4-6 glasses per day \_\_\_\_7 or more glasses per day

What amount of the above fluid intake occurs between 8 am and 6 pm? \_\_\_All \_\_\_1/2 \_\_\_3/4 \_\_\_None

What fluid and how much is taken at bedtime?

**Check the way you best learn:**

\_\_\_\_Listening (discussion, lecture, CDs); \_\_\_\_Seeing (reading, DVD’s, displays, slides);

\_\_\_\_Doing (demonstration, practicing skill); \_\_\_\_Don’t know