THRIVE
Chiropractic & Wellness Centre

HOLISTIC PELVIC CARE

Name: _____ Today's Date: _____
Date of Birth:_____(d/m/y) Age:_____ Gender: M☐ F☐ Non-binary/Other ☐
AB health care #: _____
Home Address:_____ _____
City: _____ Prov: _____ Postal Code:_____
Phone (home):_____ Phone (work):_____ Phone (cell):_____
E mail Address: _____ Occupation: _____full time ☐ part time☐
Ethnicity: _____ *(for genetic health risk assessment purposes only)*
Emergency Contact: _____ Relation:_____ Phone: _____

I consent to receiving free ongoing support and guidance via email to help me achieve better results in my health:
Yes ☐ No ☐

When was your last blood test? _____ What was tested? _____
Please bring copies of any testing or imaging you have had done in the past year.

How did you hear about Dr. Haarsma?

Dr. Haarsma's website ☐ Clinic website ☐ Referral/Recommended ☐ Internet reviews ☐
Facebook ☐ Instagram ☐ Other Social Media ☐ Other ☐ (please specify):_____

CURRENT HEALTH CONCERNS

What is the main reason that you are seeking Holistic Pelvic Care?
_____
_____
_____
_____
_____

When did this issue begin? _____ Has it been: improving☐ worsening☐ or remaining the same☐

Please list any treatments you have received for this condition (medication, surgery, massage etc.) and the results of these treatments. Please include dates.
_____
_____
_____

Please list in order of importance, any other health concerns you have.

1) _____Began when? _____

2) _____Began when? _____

3) _____Began when? _____

4) _____Began when? _____

What is your level of commitment to addressing the underlying causes of your health concerns including any necessary lifestyle changes? (10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

Please list your specific short and long term health goals.

_____

_____

REPRODUCTIVE

FEMALE

Age at 1st Period: _____
Duration of Period (Days): _____
Duration of One Cycle (From first day of period until the start of the next period): _____
Date of Last Period: _____
Period: Heavy ☐ Light ☐ Clots ☐

☐ Irregular Periods

☐ Changes in body or emotions prior to or during menstruation (Describe) (ex. Irritability, depression, emotional, anxiety, food cravings, water retention, breast tenderness, bloating, headaches, fatigue):

_____

_____

_____

☐ Bleeding Between Periods

☐ Vaginal Discharge

☐ Vaginal Sores

☐ Breast Lumps

☐ Breast Tenderness

☐ Nipple Discharge

☐ Sexual Difficulties

☐ Low Libido

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

☐ Low back pain _____
☐ Painful periods _____
☐ Pain during sex _____
☐ Pelvic / Abdominal pain _____
☐ Prolonged bleeding / Irregular menstrual cycles _____
☐ Fibroids / Ovarian Cysts _____
☐ Constipation / Irritable bowel _____
☐ Hemorrhoids _____
☐ Urinary tract infection / Bladder infections _____
☐ Tearing with birth _____
☐ Childbirth complications _____
☐ Depression _____
☐ Drug abuse _____
☐ Eating disorder _____
☐ Sexual abuse _____
☐ Physical/other abuse _____
☐ Cancer _____
☐ Smoking _____
☐ Other relevant information _____

Date of Last PAP Exam: _____ Results of previous PAP: _____
☐ History of Abnormal PAP(s)

☐ History of a Sexually Transmitted Disease (Which, Date and Treatment):
_____
_____

Are you pregnant? Yes ☐ No ☐ Maybe ☐ Are you currently breast feeding? Yes ☐ No ☐
Are you trying to conceive? Yes ☐ No ☐
Number of Pregnancies_____, Number of Live Births _____, Date and Type of deliveries (vaginal or caesarean)_____
Number of Miscarriages _____, Abortions_____
Are you sexually active? Yes ☐ No ☐
If so, do you practice birth control? Yes ☐ No ☐ What type and for how long? _____

Please list any pelvic or abdominal surgeries (include dates) _____
_____

Do you practice regular Self Breast Exams? Yes ☐ No ☐ How Often? _____
Date of Last Mammogram: _____

GENITO-URINARY

☐ Frequent Urination	☐ Inability to Hold Urine	☐ Kidney Stones
☐ Urinary Urgency	☐ Decreased Urine Flow	☐ Other Issues? _____
☐ Pain on Urination	☐ Distinctive Color	
☐ Waking to Urinate	☐ Blood in Urine	

CURRENT HEALTH HISTORY

Do you have any **allergies** to medications, foods, animals, other? If so please list. _____
_____
_____
_____

Please list all **medications** you are currently taking, including dosage and results:_____
_____
_____
_____
_____

Please list all **supplements**, herbs, vitamins or homeopathic medicines you are taking, including dosage and results:_____
_____
_____
_____
_____

How would you rate your general state of health? Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor ☐
What is your blood type? _____Current Weight: _____ Weight 1 year ago_____

Please list 5 of the most stressful events in your life, beginning with the most recent. If any of these events are currently impacting you please put a star beside these events.

1) _____Date_____

2) _____Date_____

3) _____Date_____

4) _____Date_____

5) _____Date_____

How do you manage stress (describe)

_____
_____
_____
_____

LIFESTYLE

Describe your current living arrangements: _____
_____

Describe the emotional environment of your home: _____
_____

Are you: Married☐ Separated☐ Divorced☐ Widowed☐ Single☐
Do you have a support network? _____
What do you enjoy most in your life? _____
What are your primary interests and hobbies? _____
What do you worry most about in your life? _____
Do you enjoy your job? _____

How often do you exercise per week? _____ For how long and what kind? _____

How often do you use any of the following **per week**?
Alcohol _____ Tobacco _____ Coffee_____ Black Tea _____
Soft Drinks_____ Laxatives _____ Pain Medication _____ Antacids_____
Sleeping Medication _____Marijuana _____ Other Recreational Drugs_____

Do you have any dietary restrictions, religious, ethical or other? _____
_____

Please describe your average daily diet.
Morning Midday Evening

WORK AND HOME ENVIRONMENT

How long have you lived at your current address? _____
Do you know of or suspect any mold issues in your home? _____
What is the age of your home? _____ How is your home heated?_____

Can you open windows at your place of work? Yes☐ No☐
Is there an air filtration system at work? Yes☐ No☐
Are you exposed to any toxic chemicals or fumes at work? Yes☐ No☐
Are you exposed to any toxic chemicals through any of your hobbies? Yes☐ No☐
Are you exposed to second hand smoke? Yes☐ No☐

PAST MEDICAL HISTORY

Please circle any of the following childhood diseases you have had:

Typhoid fever Whooping cough Mumps Chickenpox Diphtheria Polio Roseola
Rheumatic fever Scarlet fever Measles Small pox Tuberculosis Rubella Mono

Please list any major **traumas, surgeries and/or hospitalizations** not previously mentioned above (include dates):

_____
_____
_____

Please check all of the following vaccines you have received and list the date it was received:

- ☐ Diphtheria, Pertussis, Tetanus, Polio, Haemophilus Influenza B (DPT, PHib)
- ☐ Measles, Mumps, Rubella (MMR)
- ☐ Small pox (VV)
- ☐ Influenza (flu shot)
- ☐ Hepatitis A and/or B (Hep A/B)
- ☐ Pneumococcal (Pneu C-7)
- ☐ Meningococcal (Men –C)
- ☐ Human Papilloma Virus (HPV) (Gardasil®)
- ☐ Other

Have you ever had an adverse reaction to a vaccine, if so, which one and please describe: _____
_____

Please Check and **Date** each of the following conditions that **you** have or have had in the past:

- ☐ Allergies
- ☐ Diverticulosis/ Diverticulitis
- ☐ Gall Bladder Disease
- ☐ Liver Disease/ Jaundice/ Hepatitis
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Anemia (any type)
- ☐ Angina
- ☐ Heart Disease/ Heart Attack
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Surgeries
- ☐ Depression
- ☐ Arthritis
- ☐ Osteoporosis or Osteopenia
- ☐ Other Major Illness (specify)_____

FAMILY HISTORY

	Age	Health Problems	If deceased :	
			Age at death	Cause of Death
Father				
Mother				
Siblings				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

Do any of your **relatives** currently suffer from or have they suffered from any of the following? Please indicate those which apply and list the relation.

- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Cancer
- ☐ Cataracts
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Genetic Disease
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Syphilis
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer

REVIEW OF SYMPTOMS

Please check all of the following symptoms you are **currently experiencing** or experience as a recurring issue.

GENERAL

- ☐ Night Sweats
- ☐ Sweat Easily
- ☐ Fatigue
- ☐ Chills
- ☐ Fevers
- ☐ Poor Appetite
- ☐ Change in Appetite
- ☐ Cravings
- ☐ Strong Thirst
- ☐ Weight Gain
- ☐ Easy Weight Gain
- ☐ Heat or Cold Intolerance
- ☐ Weight Loss
- ☐ Sudden Drop in Energy (time?)_____
- ☐ Bleed or Bruise Easily
- ☐ Strange Tastes or Smells

SLEEP

- ☐ Problems Sleeping anytime during Life
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Grind Teeth
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Nightmares, describe any Recurring Nightmares:_____

_____

_____

How do you prefer your covers? On ☐ Off ☐
How do you prefer the room when you are sleeping? Hot ☐ Cold ☐ Don't Care ☐
Do you sleep with a window open? Yes ☐ No ☐
Please describe your preferred sleep position (back, abdomen, side):_____

How many hours do you sleep each night on average? _____ Do you wake rested? _____
Average Bedtime:_____ Average Wake Time: _____ Is this consistent? _____

SKIN, HAIR AND NAILS

- ☐ Rashes or Hives
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Pimples
- ☐ Loss of Hair
- ☐ Dandruff
- ☐ Changes in Hair or Skin Texture
- ☐ Recent Moles
- ☐ Lumps
- ☐ Ulcerations
- ☐ Peeling Nails
- ☐ Ridges in Nails
- ☐ Other Skin Nail or Hair Issue not listed?

HEAD, EYES, EARS, NOSE AND THROAT

- ☐ Headaches
- ☐ Neck Pain
- ☐ Concussion(s)
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Blurred/ Double Vision
- ☐ Tearing or Dryness
- ☐ Use of Glasses

_____Date of last eye exam

- ☐ Night Blindness
- ☐ Color Blindness
- ☐ Blind Spots
- ☐ Cataracts
- ☐ Earaches
- ☐ Poor Hearing
- ☐ Ringing in the Ears (Tinnitus)
- ☐ Use of Hearing Aid
- ☐ Facial Pain
- ☐ Sinus Issues
- ☐ Nose Bleeds
- ☐ Jaw Pain or Clicking
- ☐ Tooth Pain
- ☐ Gingivitis
- ☐ Amalgam (silver colored metal) fillings

Date of last dental exam_____

- ☐ Recurrent Sore Throats
- ☐ Sores on Lips, Tongue or inside of Cheeks

HEART AND CIRCULATION

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Palpitations / Fluttering
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Cold Hands and Feet
- ☐ Swelling of Hands
- ☐ Swelling of Feet

BREATHING AND LUNGS

- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Pain with a Deep Breath
- ☐ Cough (Blood?)
- ☐ Bronchitis
- ☐ Asthma
- ☐ Phlegm (color and consistency?)
- ☐ Pneumonia
- ☐ Other Issues not listed

DIGESTION AND ELIMINATION

- ☐ Issues swallowing
- ☐ Bad Breath
- ☐ Heartburn
- ☐ Abdominal Pain or Cramping
- ☐ Bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Gas
- ☐ Constipation
- ☐ Chronic Laxative Use
- ☐ Rectal Pain
- ☐ Rectal Sores
- ☐ Hemorrhoids
- ☐ Diarrhea or Loose Stools

Please describe your preference for the following tastes:

Sweet	Love It! ☐	Don't like it at all ☐	Take it or leave it ☐
Salty	Love It! ☐	Don't like it at all ☐	Take it or leave it ☐
Sour	Love It! ☐	Don't like it at all ☐	Take it or leave it ☐
Vinegar	Love It! ☐	Don't like it at all ☐	Take it or leave it ☐
Bitter	Love It! ☐	Don't like it at all ☐	Take it or leave it ☐

Are you generally a very thirsty person? Or do you not think about drinking?_____
Do you sip or gulp your water?_____
Do you prefer hot or cold beverages?_____

How many bowel movements do you have per day?_____
Are your bowel movements formed? _____ Are they generally more loose or hard? _____
Can you see any of the following in your stool? Blood ☐ Mucous ☐ Undigested food ☐
What is the color of your stool? _____ Has it ever been black? Yes ☐ No ☐
Do your stools generally float? _____ Are your stools generally greasy? _____

MUSCLES, JOINTS AND BONES

- ☐ Neck Pain
- ☐ Back Pain
- ☐ Hand/ Wrist Pain
- ☐ Shoulder Pain
- ☐ Knee Pain
- ☐ Foot/ Ankle Pain
- ☐ Hip Pain
- ☐ Other Joint or Bone Problems?
- ☐ Muscle Pain
- ☐ Muscle Weakness

BRAIN, NERVES AND EMOTIONS

- ☐ Loss of Balance
- ☐ Lack of Coordination
- ☐ Dizziness
- ☐ Seizures
- ☐ Areas of Numbness/ Tingling/ Paralysis
- ☐ History of Concussion
- ☐ Poor Memory
- ☐ Quick Temper
- ☐ Irritability
- ☐ Anxiety/ Nervousness
- ☐ Depression
- ☐ Susceptible to Stress

Have you ever been treated for any emotional issues?_____

Have you ever considered or attempted suicide?_____

List any other neurological or psychological issues._____

Thank you for taking the time to complete this form.

CONSENT FORM

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR FIRST VISIT

Naturopathic medicine is a style of medicine which approaches individual health, condition treatment and disease prevention primarily by natural means. Naturopathic physicians consider the whole person taking into account physical, biochemical, mental and emotional aspects of each person and work to find the root cause of disease and to stimulate the innate healing ability of the body.

If you are receiving Holistic Pelvic Care, assessment includes an internal vaginal exam to assess pelvic musculature. Treatment of findings may include internal vaginal massage, instruction in breathing and pelvic muscle exercises, rectal assessment and other techniques, as needed.

There is a slight potential for risk involved in naturopathic medical care and holistic pelvic care. These risks include but are not limited to the following:

- Allergic reaction to supplements, herbs, topical products or injectable components
- Aggravation of preexisting symptoms or condition(s)
- Mild pain, bruising or minor bleeding following acupuncture, injection therapies or venipuncture
- Soreness or bleeding following Holistic Pelvic Care assessment and/or treatment, as well as emotional response to treatment

I _____understand that my identity will be protected at all times and that a health record will be kept detailing health services provided to me. This record will be kept confidential and will only be released under my specific direction or as required by law. I understand that I may see my medical record at any time during regular business hours and that a copy can be requested for a fee. I also consent to the use of information in my medical record for research purposes and understand that my identity will always be protected and kept absolutely confidential.

I commit to informing my Naturopathic Doctor immediately of any disease or condition I am suffering from and will continue to update my Naturopathic Doctor with all pertinent changes in my health. I will also inform my Naturopathic Doctor immediately if I become pregnant or suspect that I am pregnant or if I am breast feeding.

I understand and agree that if at any time I experience symptoms that concern me regarding Holistic Pelvic Care or if I have difficulty integrating a Holistic Pelvic Care session, I will promptly consult my Naturopathic Doctor or other provider (psychologist, counselor, therapist).

I understand that the Naturopathic Doctor will answer any of my questions to the best of her ability. I understand that results are not guaranteed. I do not expect the Naturopathic Doctor to anticipate and explain all risks and potential complications involved in naturopathic care. With this knowledge, I voluntarily consent to diagnostic and treatment procedures by my Naturopathic Doctor. I understand that my consent, as indicated on this form, will cover the entire duration of my clinical relationship with my naturopathic doctor. I also understand that I am free to withdraw this consent through written notification and may discontinue participation in any procedure at any time.

Patient Name: (please print) _____

Signature of Patient: _____

Date: _____