



HOLISTIC PELVIC CARE
HEALTH QUESTIONNAIRE

PERSONAL INFORMATION

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Inability to Hold Urine | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Urinary Urgency | <input type="checkbox"/> Decreased Urine Flow | <input type="checkbox"/> Other Issues? _____ |
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Distinctive Color | |
| <input type="checkbox"/> Waking to Urinate | <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Diphtheria, Pertussis, Tetanus, Polio,
Haemophilus Influenza B (DPT, PHib) | <input type="checkbox"/> Hepatitis A and/or B (Hep A/B) |
| <input type="checkbox"/> Measles, Mumps, Rubella (MMR) | <input type="checkbox"/> Pneumococcal (Pneu C-7) |
| <input type="checkbox"/> Small pox (VV) | <input type="checkbox"/> Meningococcal (Men -C) |
| <input type="checkbox"/> Influenza (flu shot) | <input type="checkbox"/> Human Papilloma Virus (HPV) (Gardasil®) |
| | <input type="checkbox"/> 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:

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

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.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Genetic Disease | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Schizophrenia | |

REVIEW OF SYMPTOMS

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

GENERAL

- | | | |
|--|---|---|
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Cravings | <input type="checkbox"/> Sudden Drop in Energy
(time?) _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Bleed or Bruise Easily |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Strange Tastes or Smells |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Easy Weight Gain | |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Heat or Cold Intolerance | |

SLEEP

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Problems Sleeping
anytime during Life | <input type="checkbox"/> Difficulty Staying Asleep | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Grind Teeth | |
| <input type="checkbox"/> Nightmares, describe any Recurring Nightmares: _____ | <input type="checkbox"/> Snoring | |
-
-

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Rashes or Hives | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Peeling Nails |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Changes in Hair or Skin
Texture | <input type="checkbox"/> Ridges in Nails |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Recent Moles | <input type="checkbox"/> Other Skin Nail or Hair
Issue not listed? |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Lumps | |
| <input type="checkbox"/> Pimples | <input type="checkbox"/> Ulcerations | |
| <input type="checkbox"/> Loss of Hair | | |

HEAD, EYES, EARS, NOSE AND THROAT

- | | | |
|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Blind Spots | <input type="checkbox"/> Tooth Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Gingivitis |
| <input type="checkbox"/> Concussion(s) | <input type="checkbox"/> Earaches | <input type="checkbox"/> Amalgam (silver colored metal) fillings |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Poor Hearing | Date of last dental exam_____ |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Ringing in the Ears (Tinnitus) | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Blurred/ Double Vision | <input type="checkbox"/> Use of Hearing Aid | <input type="checkbox"/> Sores on Lips, Tongue or inside of Cheeks |
| <input type="checkbox"/> Tearing or Dryness | <input type="checkbox"/> Facial Pain | |
| <input type="checkbox"/> Use of Glasses | <input type="checkbox"/> Sinus Issues | |
| _____ Date of last eye exam | <input type="checkbox"/> Nose Bleeds | |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Jaw Pain or Clicking | |
| <input type="checkbox"/> Color Blindness | | |

HEART AND CIRCULATION

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cold Hands and Feet |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Fainting | <input type="checkbox"/> Swelling of Hands |
| <input type="checkbox"/> Palpitations / Fluttering | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Swelling of Feet |

BREATHING AND LUNGS

- | | | |
|--|--|---|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other Issues not listed? |
| <input type="checkbox"/> Pain with a Deep Breath | <input type="checkbox"/> Phlegm (color and consistency?) | |
| <input type="checkbox"/> Cough (Blood?) | | |

DIGESTION AND ELIMINATION

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Issues swallowing | <input type="checkbox"/> Bloating | <input type="checkbox"/> Chronic Laxative Use |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Nausea | <input type="checkbox"/> Rectal Pain |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Rectal Sores |
| <input type="checkbox"/> Abdominal Pain or | <input type="checkbox"/> Gas | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea or Loose Stools |

Please describe your preference for the following tastes:

- | | | | |
|---------|-----------------------------------|---|--|
| Sweet | Love It! <input type="checkbox"/> | Don't like it at all <input type="checkbox"/> | Take it or leave it <input type="checkbox"/> |
| Salty | Love It! <input type="checkbox"/> | Don't like it at all <input type="checkbox"/> | Take it or leave it <input type="checkbox"/> |
| Sour | Love It! <input type="checkbox"/> | Don't like it at all <input type="checkbox"/> | Take it or leave it <input type="checkbox"/> |
| Vinegar | Love It! <input type="checkbox"/> | Don't like it at all <input type="checkbox"/> | Take it or leave it <input type="checkbox"/> |
| Bitter | Love It! <input type="checkbox"/> | Don't like it at all <input type="checkbox"/> | Take it or leave it <input type="checkbox"/> |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Other Joint or Bone Problems? |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Foot/ Ankle Pain | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Hand/ Wrist Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Shoulder Pain | | |

BRAIN, NERVES AND EMOTIONS

- | | | |
|---|---|--|
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Areas of Numbness/ Tingling/ Paralysis | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> History of Concussion | <input type="checkbox"/> Anxiety/ Nervousness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Quick Temper | <input type="checkbox"/> 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: _____