10. What is your living situation?

__ Assisted Living __ Live with spouse/partner __ Live with caregiver __Live with family
__ Single/Widowed __ Receiving home health care __ Other _____

11. Occupation: _____ Circle all that apply: Full time/Part time/Retired/Disability/Leave

12. Amount and type of exercise per week: _____

13. How have your symptoms limited daily activities? _____

14. **Females only** (Please write number of each)

____Pregnancies ____ Vaginal deliveries ____Episiotomies ____ C-Sections

Have you experienced difficult childbirth? (explain) _____

15. Have you ever had any of the following conditions or diagnoses (please circle all that apply)

Smoking/ tobacco use	High blood pressure	Pelvic Congestion	Childhood bladder problems
History of falling	Cancer: _____	PID	Depression/ Anxiety
Physical/sexual abuse	Immnosupression	Pudendal Neuralgia	Chronic Fatigue Syndrome
Heart Problems	Lupus	Pelvic pain	Joint replacement
Cauda Equina	Obesity	Prostate Disorder	Sports Injuries
Stroke	Arthritis	TMJ/ Neck Pain	Latex Sensitivity
Current Infection	Head Injury	Headaches	Irritable Bowel Syndrome
Diabetes Type I/ II	Dysmenorrhea	Osteoporosis	Sexually transmitted Disease
Fibromyalgia	Endometriosis	Epilepsy/ Seizures	Menopause (when) _____
Fracture: _____	Fibroids	Multiple Sclerosis	Other _____

16. Have you had any diagnostic testing or imaging related to this problem? (type/ results) _____

_____

17. Since the onset of your symptoms, have you had: (check all that apply)

__ Unexplained weight change __ Unexplained weakness __Change in bowel/ bladder function
__ Fever/ Chills __ Night pain/ sweats __Malaise (generalized discomfort)
__ Dizziness/ Fainting __ Numbness/ tingling __Unexplained fatigue
__ Other, please list _____

18. Medications/Supplements/Herbal (pills, injections, patch, etc. Please include birth control and OTC)

Prescription?	Medication/ Dose	Start Date	Reason
Y/N			
Y/N			
Y/N			
Y/N			
Y/N			

19. What are your goals for treatment? _____