

**THESE FORMS ARE ONLY**  
**FOR WOMEN INTERESTED**  
**IN THE O SHOT**  
**(to improve urinary and  
sexual function)**



**Billing Questionnaire**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone #: Home \_\_\_\_\_ Mobile \_\_\_\_\_

Email address: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Primary Care Physician/Clinic Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Significant Other/Partner Name:

Emergency Contact Name (if not the same as above):

Emergency Contact Phone #:

Employer Name:

Insurance Info: BRING IN CARD TO PHOTOCOPY

Guarantor's Name:

Guarantor's DOB:

**Female History Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

Occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Other Practitioners (massage, chiropractor, acupuncturist, physicians)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Are you still menstruating? Y N

If not, when was your last period? \_\_\_\_\_

Do you take any hormones? Y N

If so, please list them: \_\_\_\_\_

If not, have you ever taken hormones? Including birth control pills, shots, or implants?

Y N

Which ones? \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_

How many children have you had? \_\_\_\_\_

How many vaginal births? \_\_\_\_\_ or C-sections? \_\_\_\_\_

Have many miscarriages or abortions? \_\_\_\_\_

Have you had any female surgeries, other than C-section? Y N

What? When? \_\_\_\_\_

Did it fix the problem? \_\_\_\_\_

**Allergies/Sensitivities**

_____	_____
_____	_____
_____	_____

**Past Surgery, Hospitalizations, and/or Accidents**

Date	Surgery/Medical Issue
_____	_____
_____	_____
_____	_____
_____	_____

**Medications & Supplements**

Name	Dose	Frequency	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Social**

Do you drink Alcohol?                      Y   N      How much? \_\_\_\_\_

Do you use Tobacco?                        Y   N      How much? \_\_\_\_\_

    If you did in the past, when did you quit? \_\_\_\_\_

Do you follow a special Diet?            Y   N              What type? \_\_\_\_\_

Do you exercise regularly?                Y   N              How much? \_\_\_\_\_

Do you have any other Hobbies?        Y   N              What are they? \_\_\_\_\_

What is your height? \_\_\_\_\_      What is your weight? \_\_\_\_\_

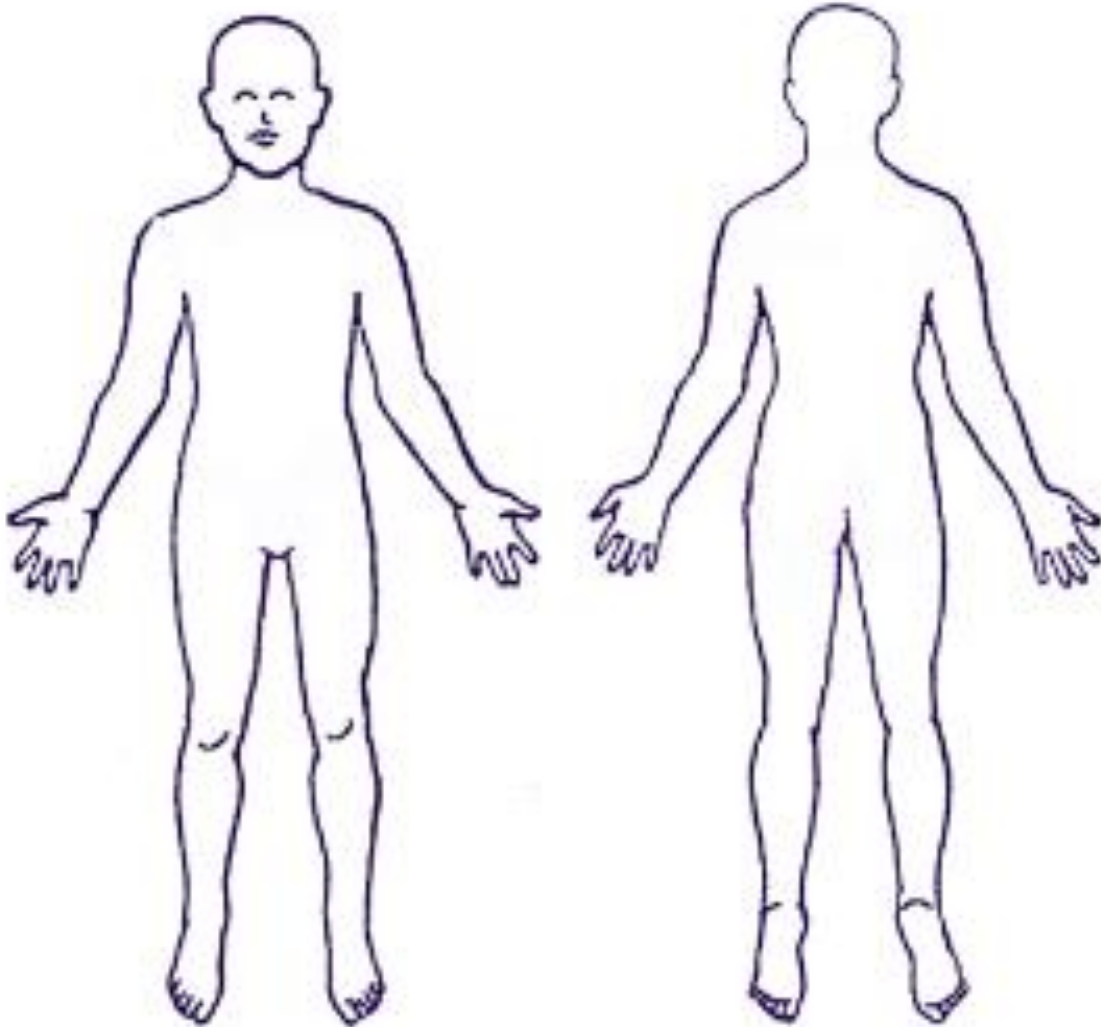
Do you ever have pelvic pain (in your genitals, perineum, pubic, or bladder area, or with urination) that exceeds a “3” on a 1-10 pain scale, with 10 being the worst pain imaginable?	yes	no
Have you ever had any falls onto your tailbone, lower back, or buttocks (even in childhood) that you remember?	yes	no
Do you ever experience <i>any</i> of the following urinary symptoms? <ul style="list-style-type: none"> <li>• Accidental loss of urine when coughing, laughing, sneezing or exercising?</li> <li>• Accidental loss of urine with strong, uncontrollable urge?</li> <li>• Feeling that you cannot completely empty your bladder</li> <li>• Having to void within a few minutes of a previous void?</li> <li>• Pain or burning with urination?</li> <li>• Difficulty starting a urine stream?</li> <li>• Frequent stopping/starting of urine stream?</li> </ul>	yes	no
Do you often or occasionally have to get up to urinate <i>two or more</i> times at night?	yes	no
Do you ever have a feeling of increased pelvic pressure or the sensation of your pelvic organs slipping down or falling out?	yes	no
Do you have a history of <i>any</i> of the following orthopedic pain conditions? <ul style="list-style-type: none"> <li>• Low back pain</li> <li>• Sciatica</li> <li>• Hip pain</li> <li>• Groin strain</li> <li>• Tailbone pain</li> </ul>	yes	no
Do you ever experience <i>any</i> of the following bowel symptoms? <ul style="list-style-type: none"> <li>• Loss of bowel control when coughing, laughing or sneezing</li> <li>• Loss of bowel control with strong, uncontrollable urge</li> <li>• Feeling that you cannot completely empty your bowels</li> <li>• Experiencing increased pain with a bowel movement</li> <li>• Frequently must strain to have a bowel movement</li> <li>• Have difficulty initiating a bowel movement</li> </ul>	yes	no
Do you ever experience pain or discomfort with sexual activity or intercourse?	yes	no
Does sexual activity increase any of your other symptoms?	yes	no
Does prolonged sitting increase any of your symptoms?	yes	no
Scoring: 3 or more “yes” suggests pelvic floor dysfunction		

**Do you have any of the following? (circle all that apply)**

Urine leakage	Weight gain/loss	Trouble sleeping
Low desire to have sex	Brain Fog	Low Energy
Trouble with orgasm	Hair Loss	Brittle nails
Pain with sex	Temperature Intolerances	Hot Flashes
Vaginal Dryness	Heavy Period/Cramps	Bleeding Gums

**Past Medical History & Family History**

	SELF	Mother	Father	Siblings	Grand- parents	Children
Alcoholism						
Alzheimer						
Arthritis						
Asthma/Lung Issues						
Bleeding Disorder						
Cancer(s)						
Depression/ Anxiety						
Diabetes						
Drug Abuse						
Epilepsy						
Glaucoma/Eye problems						
Heart Disease: (attack, palpitations)						
High Cholesterol						
High Blood Pressure						
Intestinal Issues: IBS, stomach						
Kidney Disease						
Liver Disease: Hepatitis						
Migraines						
Thyroid Issues						
OTHER:						



PLEASE INDICATE WHERE YOU ARE EXPERIENCING:

**PAIN** with an X

**DISCOMFORT** with ///

**RADIATION** of the pain or discomfort with #



**SELECT THE ONE WORD ON EACH LINE (1-10) THAT BEST DESCRIBES YOU:  
(Select only 1 word in each of the 10 horizontal rows.)**

1. ___ DETERMINED	___ CONVINCING	___ PREDICTABLE	___ CAUTIOUS
2. ___ STRONG WILLED	___ PERSUASIVE	___ EASY-GOING	___ ORDERLY
3. ___ DIRECT	___ EXPRESSIVE	___ KIND	___ ANALYTICAL
4. ___ BOLD	___ SOCIABLE	___ COOPERATIVE	___ PRECISE
5. ___ OUTSPOKEN	___ ANIMATED	___ PATIENT	___ LOGICAL
6. ___ DECISIVE	___ TALKATIVE	___ LOYAL	___ CONTROLLED
7. ___ DARING	___ OUTGOING	___ AGREEABLE	___ CAREFUL
8. ___ RESTLESS	___ ENTHUSIASTIC	___ CONSIDERATE	___ THOROUGH
9. ___ COMPETITIVE	___ INSPIRING	___ CONSISTENT	___ DETAILED
10. ___ AGGRESSIVE	___ PLAYFUL	___ SATISFIED	___ ACCURATE

(updated 11/8/21)