Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE

THESE FORMS ARE ONLY FOR WOMEN INTERESTED IN THE O SHOT

(to improve urinary and sexual function)

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PLEASE COMPLETE ALL FORMS WITH BLACK INK PEN

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:

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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? _____

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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? _____

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Cozean Pelvic Dysfunction Screening Protocol

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 *any* of the following urinary symptoms? • Accidental loss of urine when coughing, laughing, sneezing or exercising? • Accidental loss of urine with strong, uncontrollable urge? • Feeling that you cannot completely empty your bladder • Having to void within a few minutes of a previous void? • Pain or burning with urination? • Difficulty starting a urine stream? • Frequent stopping/starting of urine stream?	yes	no
Do you often or occasionally have to get up to urinate *two or more* 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 *any* of the following orthopedic pain conditions? • Low back pain • Sciatica • Hip pain • Groin strain • Tailbone pain	yes	no
Do you ever experience *any* of the following bowel symptoms? • Loss of bowel control when coughing, laughing or sneezing • Loss of bowel control with strong, uncontrollable urge • Feeling that you cannot completely empty your bowels • Experiencing increased pain with a bowel movement • Frequently must strain to have a bowel movement • Have difficulty initiating a bowel movement	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

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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:						

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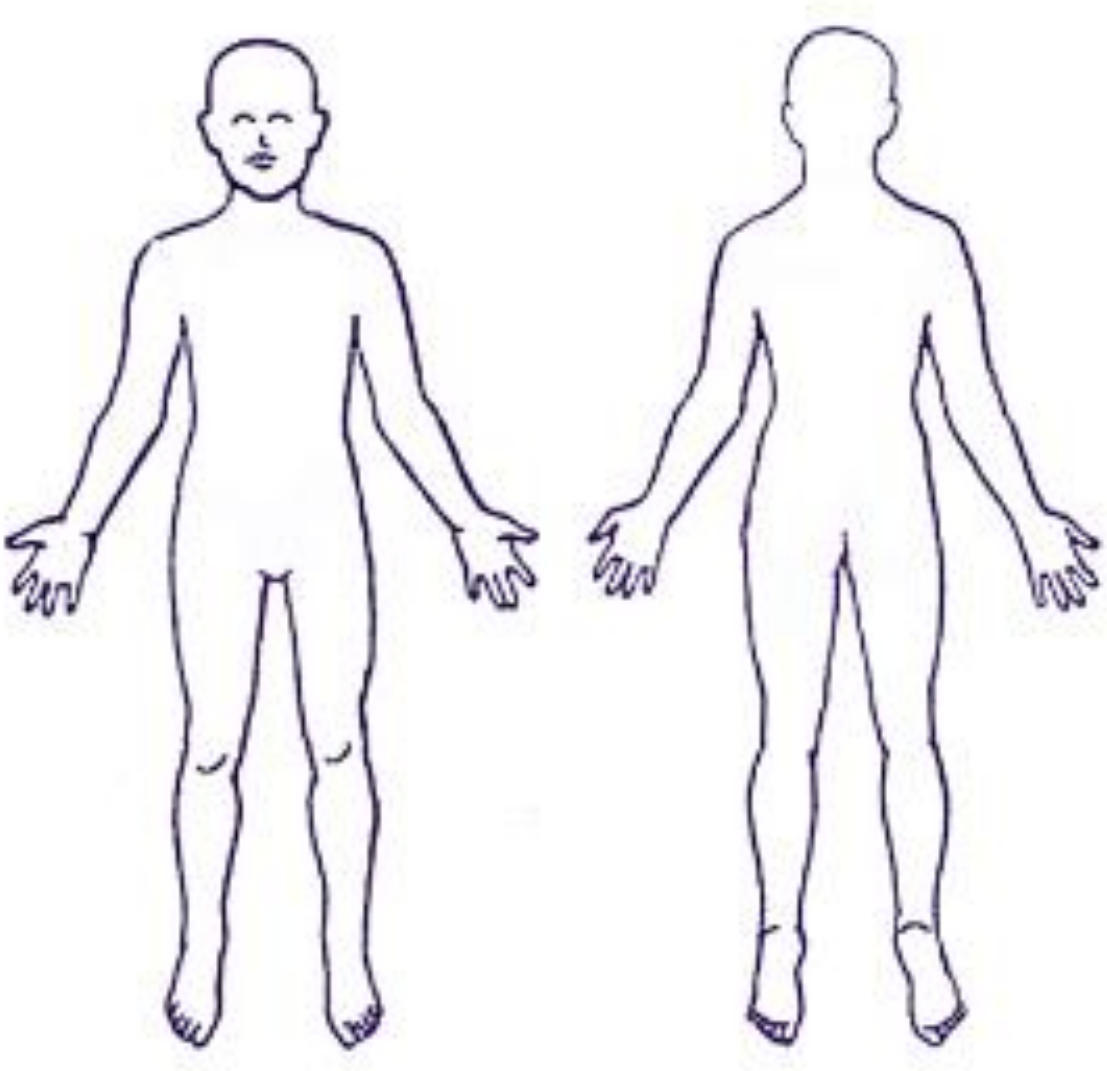

PLEASE INDICATE WHERE YOU ARE EXPERIENCING:

PAIN with an X

DISCOMFORT with ////

RADIATION of the pain or discomfort with #

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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 8/8/23)

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