Recover Your Core: Birth History

Name: _____

Age:_____

Email:)_____ **Phone Number:**_____

Area of Town: (circle) Jensen Beach Stuart Palm City Ft. Pierce Palm Beach Jupiter Hobe Sound Port St. Lucie Okeechobee

Do you currently experience any of the following? (Please circle and list how often next to it)

a. Pelvic Floor Pain Bladder Control Issues Low/Mid/Upper back pain
Small sprinkle of urine during a cough, sneeze, or exercise
Neck Pain Pressure in Pelvic Floor or Anus Constipation/Trouble passing stool Hernia
Fluffy Tummy Pain during intercourse Diastasis Uterine Prolapse Rectocele Enterocele
Cystocele Urethrocele Pubic Synthesis Pelvic Joint Pain
Abdominal Discomfort During Exercise Other:_____

b. Scar Tissue Issues- (if so which kind?) Cesarean Scarring Perineum Scarring Episiotomy Scarring
Other: (tell me about it?) _____

c. During daily activity or exercise, do you ever experience urinary leakage, or find that your underwear is often wet? (consider when you squat, bend over, walk, jump, ect) Yes No I Don't Know

Please do your best to answer these questions as honestly as possible regarding urinary and bowel habits:

Do you ever feel a bulging sensation in the vagina? If yes, do your symptoms become worse when standing, and improve when lying down?	Yes Yes	No No	I Don't Know I Don't Know
Have you noticed your urinary stream slowing down?	Yes	No	I Don't Know
After you empty your bladder, does it ever still feel full?	Yes	No	I Don't Know
Do you regularly experience Bladder Infections?	Yes	No	I Don't Know
Do you ever feel as though your rectum is full and isn't fully relieved?	Yes	No	I Don't Know
Do you ever feel pressure at the rectum?	Yes	No	I Don't Know
Do you ever have difficulty pushing out stool, even though it's right there?	Yes	No	I Don't Know
Do you ever experience soiling your underwear from the bowels?	Yes	No	I Don't Know
Do you ever have gas escape without your knowledge or control?	Yes	No	I Don't Know

Number of Live Births: _____

Can you tell me about each of your births?

1. **Birth Date**_____
   Type of Birth: Vaginal or Cesarean
   a. If Vaginal, did you have any tearing? Yes or No
   b. If so, what degree and where?_____
   If Cesarean,
   a. How does your scar and abdominal region feel now? _____
   _____
   _____
   b. Would you say that full feeling has returned to the area of your scar? Yes or No
   Were any interventions used: Induction Electronic Fetal Monitoring Episiotomy
   Epidural Use of Foreceps Vacuume Assisted
   If interventions were used, are you still experiencing any discomfort related to the intervention?_____
   Anything else you want to share related to this birth?_____
   _____

2. **Birth Date**_____
   Type of Birth: Vaginal or Cesarean

c. If Vaginal, did you have any tearing? Yes or No
d. If so, what degree and where?_____

If Cesarean,

c. How does your scar and abdominal region feel now? _____

_____

_____

d. Would you say that full feeling has returned to the area of your scar? Yes or No

Were any interventions used: Induction Electronic Fetal Monitoring Episiotomy
Epidural Use of Foreceps Vacuume Assisted
If interventions were used, are you still experiencing any discomfort related to the intervention?_____

Anything else you want to share related to this birth?_____

_____

3. **Birth Date**_____

Type of Birth: Vaginal or Cesarean

e. If Vaginal, did you have any tearing? Yes or No
f. If so, what degree and where?_____

If Cesarean,

e. How does your scar and abdominal region feel now? _____

_____

_____

f. Would you say that full feeling has returned to the area of your scar? Yes or No

Were any interventions used: Induction Electronic Fetal Monitoring Episiotomy
Epidural Use of Foreceps Vacuume Assisted
If interventions were used, are you still experiencing any discomfort related to the intervention?_____

Anything else you want to share related to this birth?_____

_____

Need more space to write about your births? Please ask for another sheet ☺

Please tell me about any past injuries, illnesses, or pertinent medical information that would help me to better serve you during these six weeks_____

_____

_____

_____

_____

_____

_____

_____

Do you currently exercise? (please circle) Yes or No

How often?_____

What do you do for exercise? (Please include activities and recreation)

_____

_____

_____

Do you experience any of the symptoms listed in question number one during exercise? If so, what?

_____

_____

How did you hear about Recover Your Core's classes?_____

Is there someone I can thank for referring you?_____

Thank you for taking the time to fill this out! Understanding your birth history and the symptoms you currently experience, will better help me to tailor our time together to meet your needs. Please know that the information listed on this page is strictly confidential and will not be viewed by anyone else but myself.

If you haven't already, please consider "Liking" my page, Recover Your Core, as well as writing a review at the end of our six weeks!