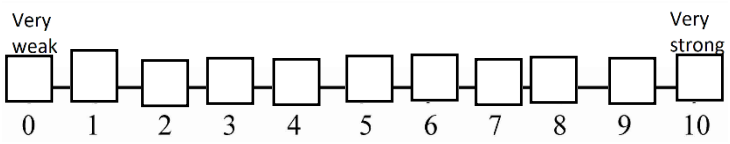
Choice Health & Wellness

Female Wellness Evaluation Questionnaire

Patient's name:	**Date:**
Phone:	**Email:**
Age:	**Date of birth:**

1. On a scale of 0-10, how would you rate your core strength? Please circle your answer.



2. How many times per night do you wake up to use the bathroom? Please circle your answer.

☐ 0-1 ☐ 2-4 ☐ 4+

3. How many times per week do you exercise? Please circle your answer.

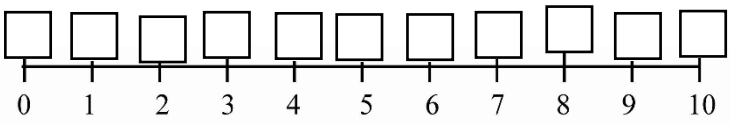
☐ 0 ☐ 1-3 ☐ 4-6 ☐ 6+

4. Which sports and exercise activities do you participate in?

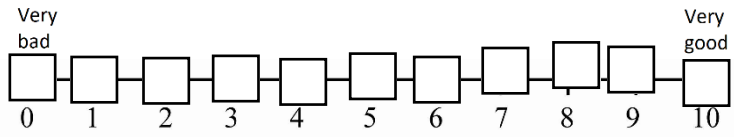
5. During the last month, how many times have you accidentally leaked urine? (e.g. when laughing, jumping, sneezing) Please circle your answer.

☐ 0 ☐ 1-3 ☐ 4-6 ☐ 6+

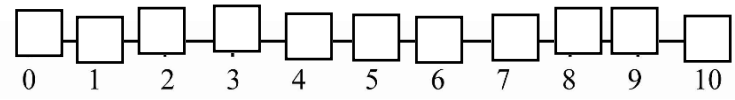
6. On a scale of 0-10, how would you rate your general level of interest in having sex? Please circle your answer.



7. On a scale of 0-10, how would you rate your level of arousal during sexual activity? Please circle your answer.



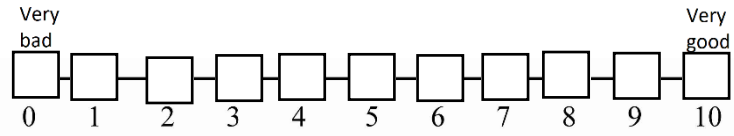
8. On a scale of 0-10, how would you rate your level of vaginal lubrication? Please circle your answer.



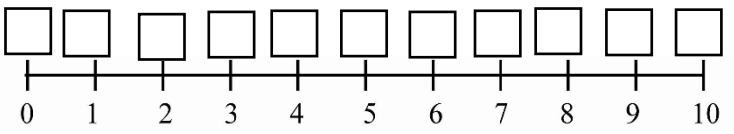
9. How often do you reach orgasm during sexual activity? Please circle one.

☐ Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always

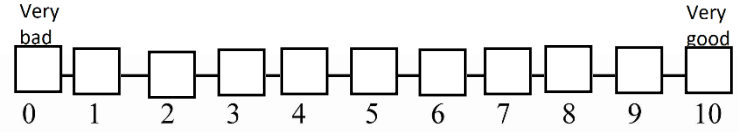
10. If you reach orgasm, how would you rate the intensity? Please circle your answer.



11. How much, if any, discomfort do you experience with intercourse? Where 0 means none and 10 means significant pain. Please circle your answer.



12. How would you rate your overall sexual satisfaction? Where 0 is none and 10 is very high. Please circle your answer.



13. Have you tried any other options (Physical Therapy, Hormone Replacement Therapy, Kegel Weights, Over the Counter Products).

14. Are you currently using birth control?

15. Are you nursing, pregnant, or may become pregnant in the near future?

16. Is there anything else you would like us to know?

17. How did you hear about our services?

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