Fit Floor Training Questionnaire

Name: _____ Birthdate: _____

Email: _____ Phone: _____

1) What is your primary reason for your interest in our Fit Floor Training program?

2) Please circle any of the following urinary symptoms that pertain to you:

   Leakage Post void dribble Pain with urination Heaviness with urination

   Burning Prolapse Full accidents: if so how many per day/week?

3) How often do you have bowel movements? _____
   Circle any that apply: Straining Pain Loose stools

4) Do you have any pain? If so, where? _____
   Circle any that apply: Low back Pelvic pain Hip pain Pain with intercourse

5) Have you ever been pregnant? If so, when and how many? _____
   Vaginal or C-section births? _____

6) Any history of surgeries/infections/GI issues? If so, please explain.
   _____
   _____

7) Any other information that you feel is important to share before beginning this program?
   _____
   _____

8) What is your primary goal you would like to get out of this program?
   _____
   _____

The program of my choice is the following: (please circle)

General Basic Intermediate Advanced

My signature below indicates that I have answered all these questions accurately and honestly. It also indicates that I understand any information not on this form or symptoms not reported could result in negative results from pelvic floor training and you take sole responsibility if that is the case. I also understand that if Champ Therapy and Wellness determines I need further evaluation before starting any of the training programs, that I will be asked to seek out a physical therapy evaluation or receive permission from my doctor before being allowed to participate.

Signature: _____ Date: _____

Name: _____