Diastasis Recti Intake

Patient Name: _____ Date: _____

Please rate the following on a scale of 1 to 10. 1 being no trouble or pain, 10 being impossible or excruciating pain.

Low back pain _____
Upper back pain _____
Hip pain _____
Abdominal Pain _____
Constipation _____
Trouble Urinating _____
GI Track/Intestinal Problems _____
Elevated PSA levels _____

Please list any sports that you have ever been involved in, or exercise classes you may be a part of as a youth or adult (i.e. swimming, gymnastics, yoga).

Have you ever had any sort of abdominal surgery? _____
If so, please briefly explain the procedure. _____
_____
_____
_____

History of pregnancy and birth if applicable: NA: _____
Are you currently pregnant? _____
If so, how far along? _____

If you answered yes to the above questions:
Please list the number of children you have had, how much each child weighed, and the type of birth you had.
_____
_____
_____
_____
_____