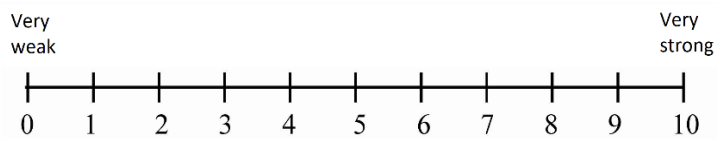
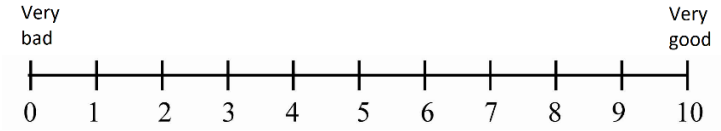
Wellness Evaluation Questionnaire

Patient's name:	**Date:**
Phone:	**Email:**
Sex: ☐ **Male** ☐**Female**	**Date of birth:**

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



2. On a scale of 0-10, how would you rate your quality of sleep?



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

0-1 2-4 4+

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

0 1-3 4-6 6+

5. Which of the following sports and exercise activities do you participate in? Please circle all that apply.

Baseball Football Basketball Cycling Cross-fit Hockey Tennis Running Volleyball
Soccer Yoga Swimming Pilates Weightlifting Golf Skiing
Other: _____

6. During the last month, have you accidentally leaked urine?(e.g. when laughing, jumping, sneezing)

Yes No

7. On a scale of 0-10, how would you rate your sexual libido?