

## **HEALTH QUESTIONNAIRE FOR WOMEN**

### **Personal Information**

Full name \_\_\_\_\_ Name you wish to be called \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: H) \_\_\_\_\_ W) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: F Insurance Company: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Who were you referred by? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

---

### **Primary Concern**

What brings you to my office? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of original condition: \_\_\_\_\_ Date of most recent occurrence: \_\_\_\_\_

Was there an event that created the condition? \_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_

What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

Is the condition getting worse? \_\_\_\_\_ Constant? \_\_\_\_\_

Worse at a certain time of day? \_\_\_\_\_

Is this condition interfering with: Work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Activity? \_\_\_\_\_ Other? \_\_\_\_\_

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Health History

List other current health issues & problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List other practitioners seen, treatments, self-care activities, and results: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List illness you have had not previously mentioned, if any: \_\_\_\_\_

\_\_\_\_\_

List all surgeries you have had, with dates and results: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been in an accident or seriously injured? (if so, please describe) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any dental or TMJ problems? Y N (if so, please describe) \_\_\_\_\_

\_\_\_\_\_

Have you had your wisdom teeth or other teeth removed? Y N \*Have you ever had a root canal? Y N

(if yes note which teeth) \_\_\_\_\_

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking (**please bring actual bottles w/pills in with you to your appointment**):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all medications and other substances (i.e.: foods) to which you are allergic: \_\_\_\_\_

## Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father \_\_\_\_\_ Mother \_\_\_\_\_ Children \_\_\_\_\_

Grandparents \_\_\_\_\_ Brothers \_\_\_\_\_ Sisters \_\_\_\_\_

## General

\*Describe your use of: Cigarettes/Tobacco \_\_\_\_\_ Alcohol \_\_\_\_\_ Other drugs \_\_\_\_\_

\*Describe your present exercise habits including frequency per week, duration, and heart rate: \_\_\_\_\_

\* How many hours per night do you sleep? \_\_\_\_ \* Do you fall right asleep? Y N \* Do you wake up feeling refreshed? Y N

\* Do you sleep through the night without awaking? Y N \* Do you remember your dreams? Y N

\* Do you snore? Y N \*Do you have night sweats? Y N \* Do you have nightmares? Y N

\* Do you grind your teeth at night (bruxism)? Y N \* Do you have restless legs (RLS)? Y N

\*When did you last receive the following (leave blank if it does not apply to you), (please remember to bring copies).

\*Cholesterol or other blood tests \_\_\_\_\_

\*Pap smear \_\_\_\_\_ \*Mammogram \_\_\_\_\_ \* Other \_\_\_\_\_

## Pain Questionnaire

(Skip to the next section if you are not currently experiencing pain.)

Please place a single vertical line through the scale below at the point that best describes your pain.  
(0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

**A = Ache**

**B = Burning**

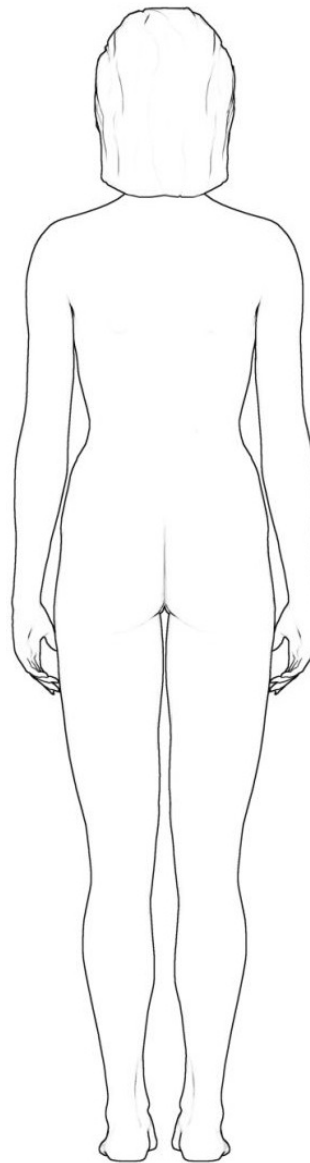
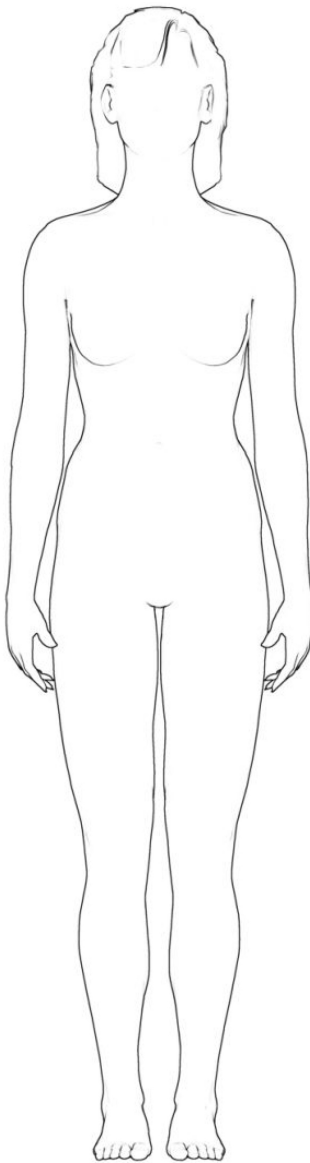
**N = Numbness**

**O = Other**

**P = Pins & Needles**

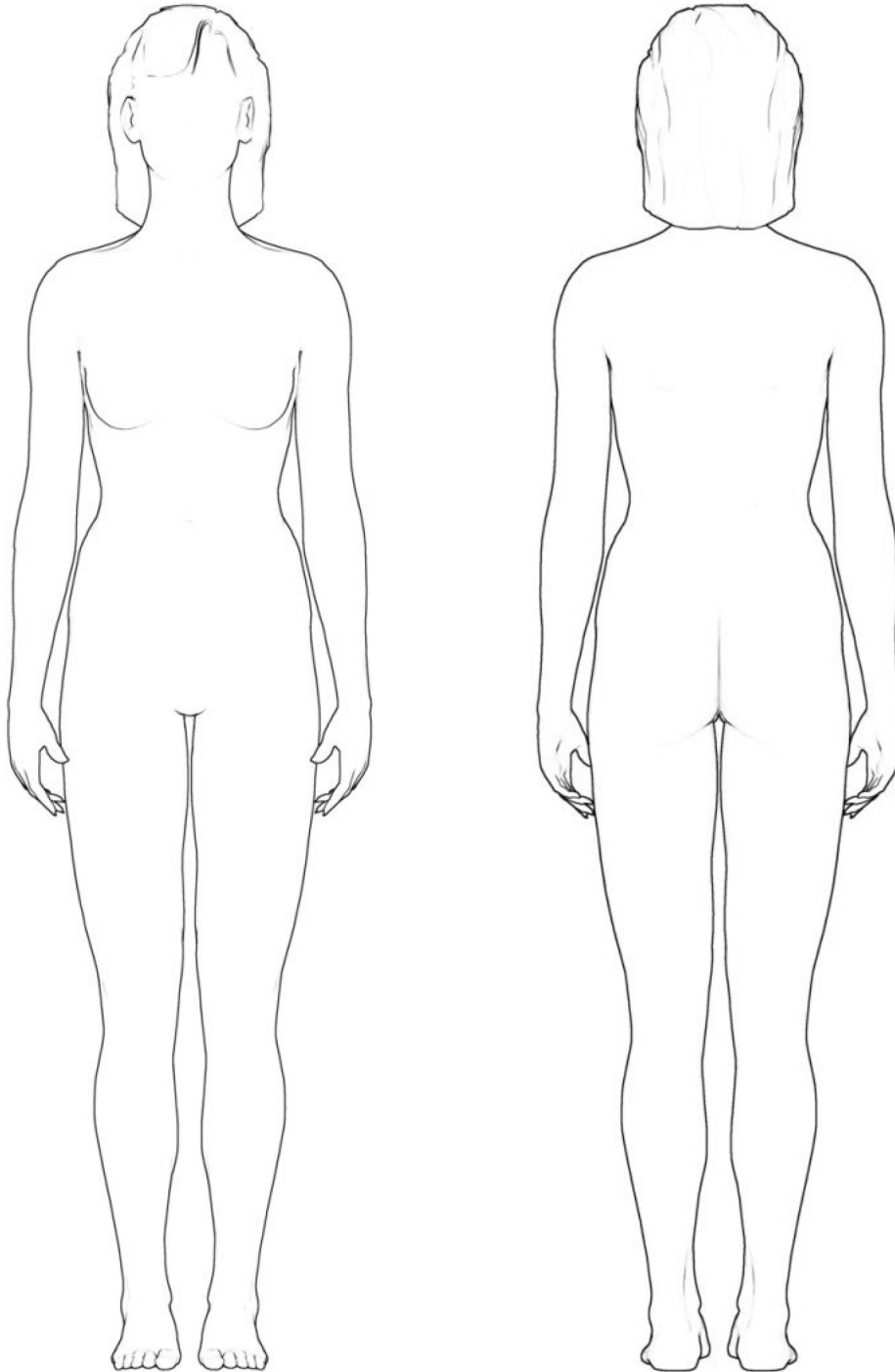
**S = Stabbing**

**T = Throbbing**



## History of Injury

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



## SYMPTOM SURVEY

Circle the symptom if you are currently experiencing it or it is a common occurrence. Underline the symptom if it is now not a problem, but was sometime in the past, (over 3 months ago).

### GENERAL

Low energy -fatigue  
Weakness  
Fever - Chills  
Headaches  
Lack of sleep  
Reduced mental acuity

### SKIN

Dry skin  
Itching  
Varicose veins  
Cold or canker sores/fever blisters  
Boils  
Hives  
Rashes  
Sores  
Change in your skin/nails

### EYES

Cataracts/Glaucoma  
Eye pain  
Double vision  
Far or near sightedness  
Flashing lights  
Spots, specks, or floaters

### EARS

Ear discharge/excessive wax  
Earaches or infections  
Hearing loss  
Ringing/tinnitus  
Vertigo/dizziness

### NOSE/SINUS

Sinus congestion  
Frequent colds/infections  
Nosebleeds

### NECK

Goiter  
Lumps  
Pain/stiffness  
Swollen glands

### RESPIRATORY

Asthma  
Bronchitis  
Cough  
Pneumonia  
Tend to hold breath  
Wheezing  
Sputum  
Trouble breathing w/exercise

### CARDIAC / VASCULAR

Arrhythmia  
Chest pain  
Heart trouble  
Murmur  
High blood pressure  
Palpitations  
Shortness of breath  
Swollen feet or lower legs  
Racing or pounding heart  
Blood clots  
Leg cramps  
Poor circulation

## MOUTH/THROAT

Bleeding gums  
Dentures  
Tooth decay  
Frequent sore throats  
Grind teeth at night  
Hoarse voice/frequent loss of voice

## NEUROLOGIC

Blackouts  
Fainting  
Numbness  
Paralysis  
Dizziness  
Tremors  
Seizures

## HEMATOLOGIC

Anemia  
Bruise easily

## ENDOCRINE

Diabetes  
Excessive thirst or hunger  
Excessive sweating  
Lack of sweating  
Heat or cold intolerance  
Thyroid problem  
Hair loss  
Dizzy when standing/rising quickly  
Excessive weight loss  
Excessive weight gain

## URINARY

Frequent urination  
Blood in urine  
Incontinence  
Painful urination  
Urinate more than once at night

## GASTROINTESTINAL

Belching  
Flatulence/gas  
Black or tarry stools  
Blood in stool  
Change in stool  
Colitis  
Constipation  
Diarrhea  
Distention  
Excessive hunger  
Heartburn  
Food intolerance  
Hemorrhoids  
Indigestion  
Nausea  
Poor appetite  
Stomach pain  
Trouble swallowing  
Vomiting

## PSYCHOLOGICAL

Anxiety  
Depression  
Insomnia / hard to fall asleep  
Nervousness  
Poor memory / forget quickly  
Violent thoughts  
Suicidal ideas  
Tend to worry

MUSCLES & JOINTS

Arthritis  
Tendonitis  
Bursitis  
Gout  
Trouble with/poor posture  
Chronic pain  
Pain with specific movement(s)  
Pain relieved with anti-inflammatory drugs (aspirin, ibuprofen, Vioxx, etc...)  
Pain, tenderness, or numbness in:  
Neck  
Shoulders  
Arms  
Elbows  
Wrist/hands  
Upper back  
Lower back  
Hips  
Knees  
Feet/ankles

SEXUAL/HORMONAL

Bleeding between periods  
Decrease sexual interest  
Pain with intercourse  
Discharge  
Itching  
Sores  
Yeast infections  
Sexually Transmitted disease  
PMS  
Breast tenderness  
Cramping/bloating  
Back Pain  
Over-emotional  
Tired/fatigue  
Other pain  
Other symptoms  
Age at first period \_\_\_\_\_  
Number of days in cycle \_\_\_\_\_  
Usual length of period \_\_\_\_\_  
Start of last menstrual period date  
\_\_\_\_\_  
Number of pregnancies \_\_\_\_\_  
Number of deliveries \_\_\_\_\_  
Complications with pregnancies  
\_\_\_\_\_  
Birth control method  
\_\_\_\_\_



## DIET HISTORY

How much do you drink each day (**8oz**): Water: \_\_\_\_\_ Juice: \_\_\_\_\_ Soda Diet: \_\_\_\_\_ Soda Regular: \_\_\_\_\_

Coffee: Regular: \_\_\_\_\_ Decaf: \_\_\_\_\_ Tea: Regular: \_\_\_\_\_ Tea Sweet : \_\_\_\_\_ Energy Drinks/Other: \_\_\_\_\_

List oils or fats that you use in cooking: \_\_\_\_\_

Do you frequently skip meals? Y N Are you on any special diet or nutrition program? Y N

Describe: \_\_\_\_\_

Are you allergic or sensitive to any foods? Y N If yes, name the foods and describe the problem.

What foods do you dislike? \_\_\_\_\_ What is/are your favorite food(s)? \_\_\_\_\_

Circle the foods you crave:

Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods  
Spicy foods Sour foods Cereals Dairy Other individual \_\_\_\_\_

\*Do you use: (circle) butter margarine shortening coconut oil \*Do you eat organic foods? Y N

\*Do you know what partially hydrogenated fats are? Y N \_\_\_\_\_ If yes, do you eat them? Y N

\*Do you eat from fast food restaurants? Y N -- If yes, how often? \_\_\_\_\_

What do you usually eat for **breakfast**? \_\_\_\_\_

What do you usually eat for **lunch**? \_\_\_\_\_

What do you usually eat for **dinner**? \_\_\_\_\_

What do you usually eat for **snacks** (in between meals and/or before bed)? \_\_\_\_\_

What foods do you eat a lot of (at least once a day, every day)? \_\_\_\_\_

How many bowel movements do you have per day? \_\_\_\_\_

### **A Bit More ----**

\*Type of sport/activity/exercise routine you participate in: \_\_\_\_\_

\*Hours you train/exercise average per week: \_\_\_\_\_ \*Do you train by yourself or with others? (circle)

\*Do you use a heart rate monitor? Y N \*What type of shoes do you wear? (Name/Style) \_\_\_\_\_

\* Do you wear orthotics/arch supports/or any other devices during the day or when you exercise?

\_\_\_\_\_

\*Have you progressed, regressed, or plateaued in the past year? (circle)

\*How many injuries (minor included) or illnesses do you suffer from per year? \_\_\_\_\_

\*If applicable: When & what is your next competition you hope to participate in, or which one do you wish to "peak" for?