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HEALTH QUESTIONAIRE 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

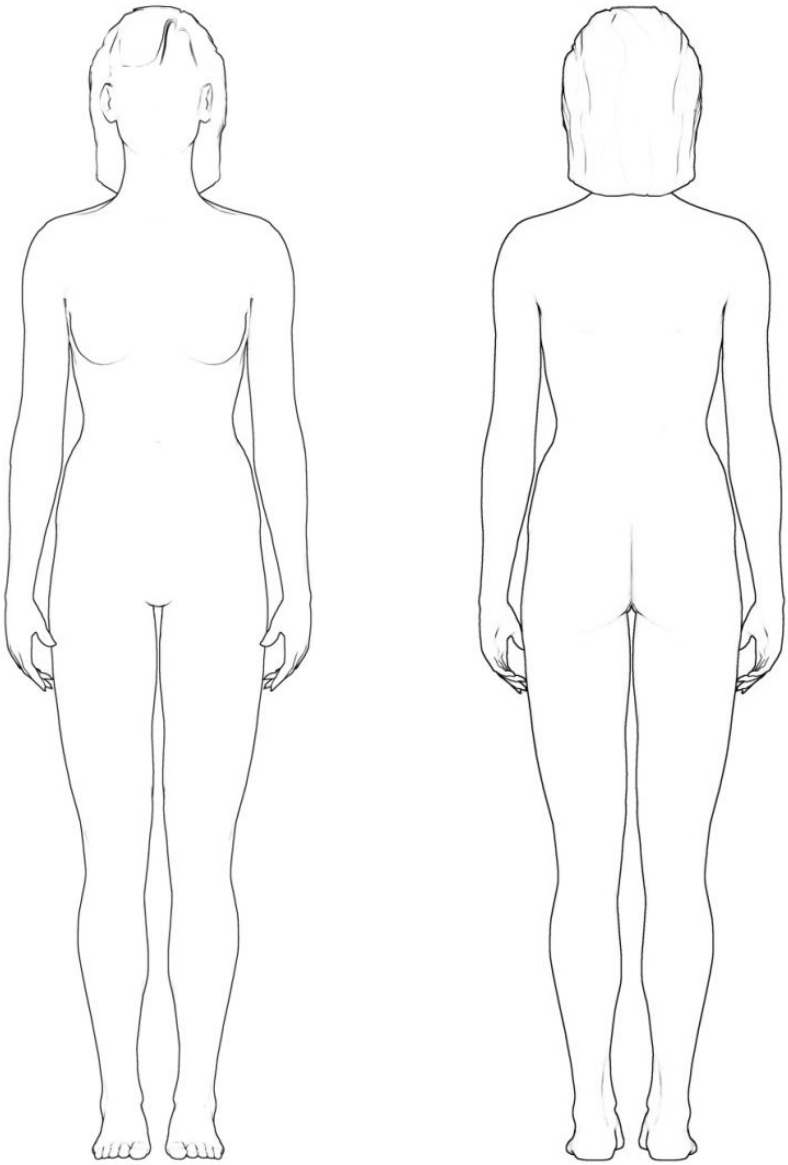
(Skip to the next section if you are not currently experiencing pain.)

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

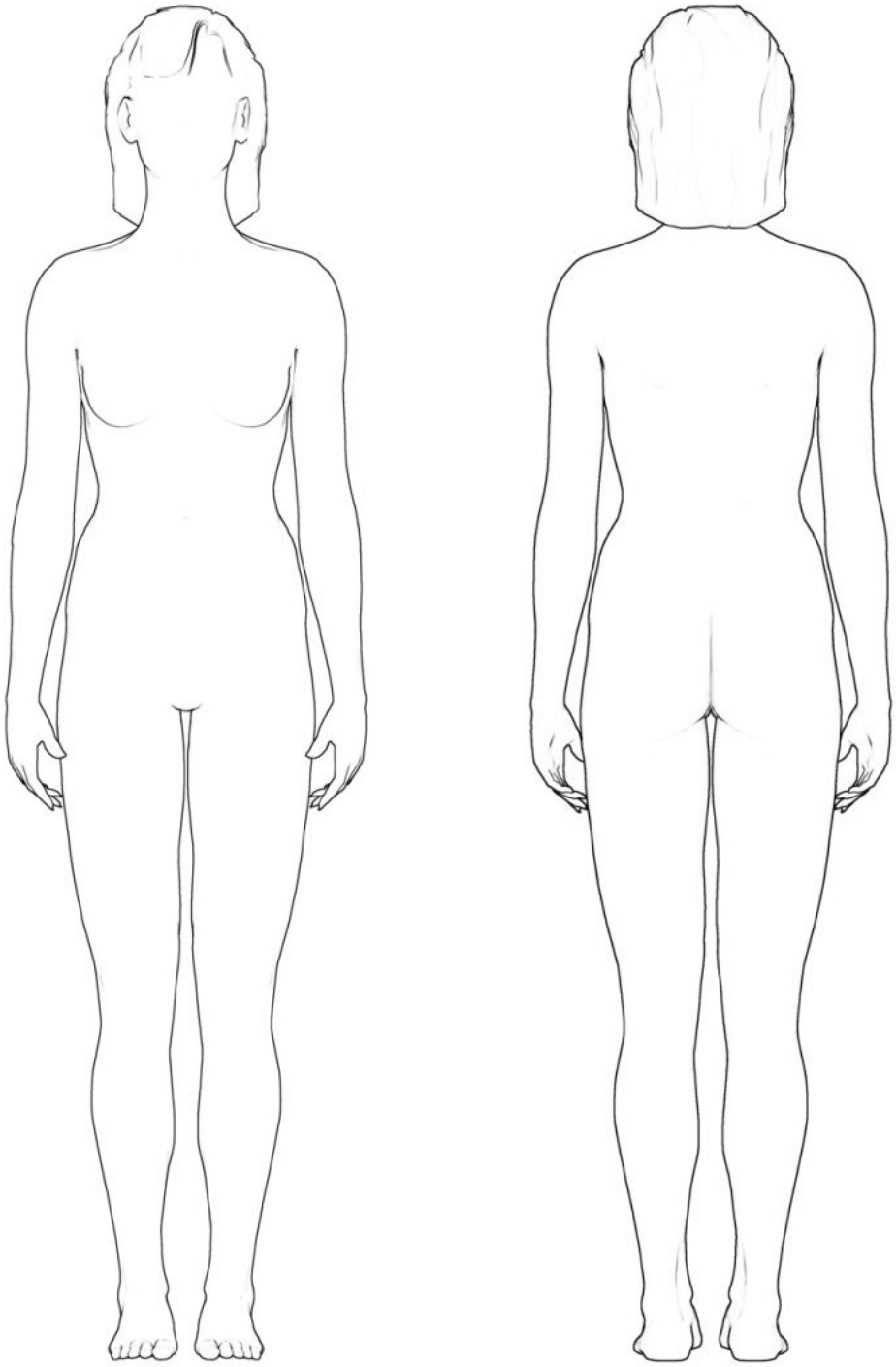
Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

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?