

## **HEALTH QUESTIONNAIRE FOR WOMEN**

### **Personal Information**

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

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

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

Phone: Mobile) \_\_\_\_\_ E-Mail: \_\_\_\_\_

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

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

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

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

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### **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

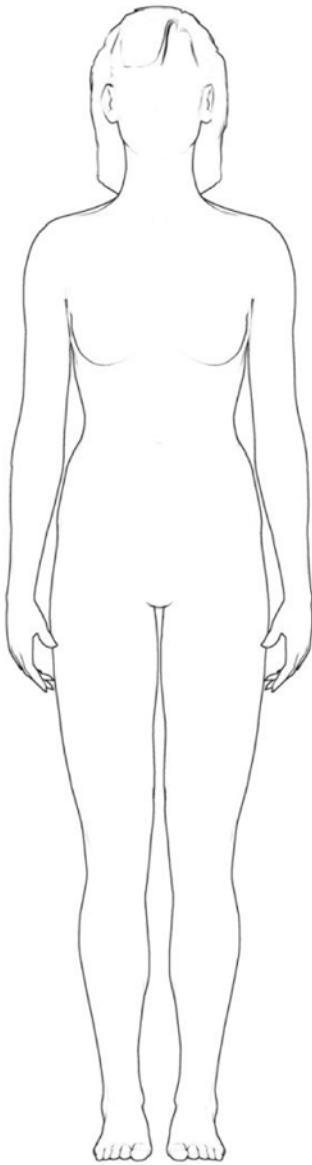
N = Numbness

O = Other

P = Pins & Needles

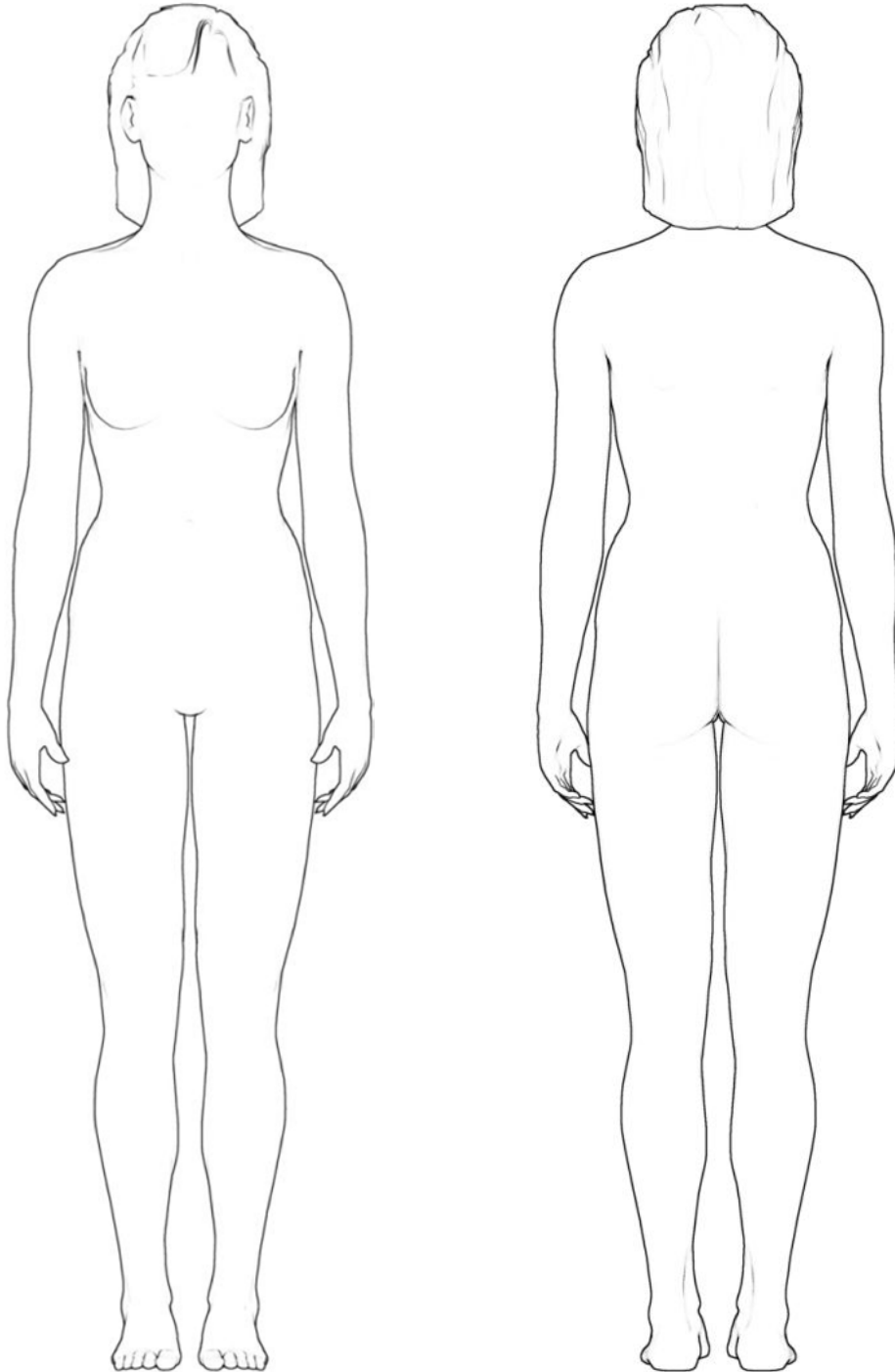
S = Stabbing

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?