Systems Health Care
Applied Kinesiology
Chiropractic Physicians

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HEALTH QUESTIONAIRE FOR FEMALES

Personal Information

Full name _____ Name you wish to be called _____

Street Address _____

City _____ State _____ Zip _____

Phone: C) _____ H) _____ E-Mail: _____

Date of birth _____/_____/_____ 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 including bruxism (grinding your teeth)? Y N (If so, please describe – **and if you wear any devices such as a nightguard or retainer please bring that with you to your appointment.**)

_____

*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: Smoking (Tobacco/Vape) _____ 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

*Do you sleep with your mouth open? Y N Unsure

*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 _____

Have you had any Covid-19 shot(s)? Is so, please note the dates and manufacturer of each one, including boosters:

_____

_____

_____

_____

_____

_____

_____

Pain Questionnaire

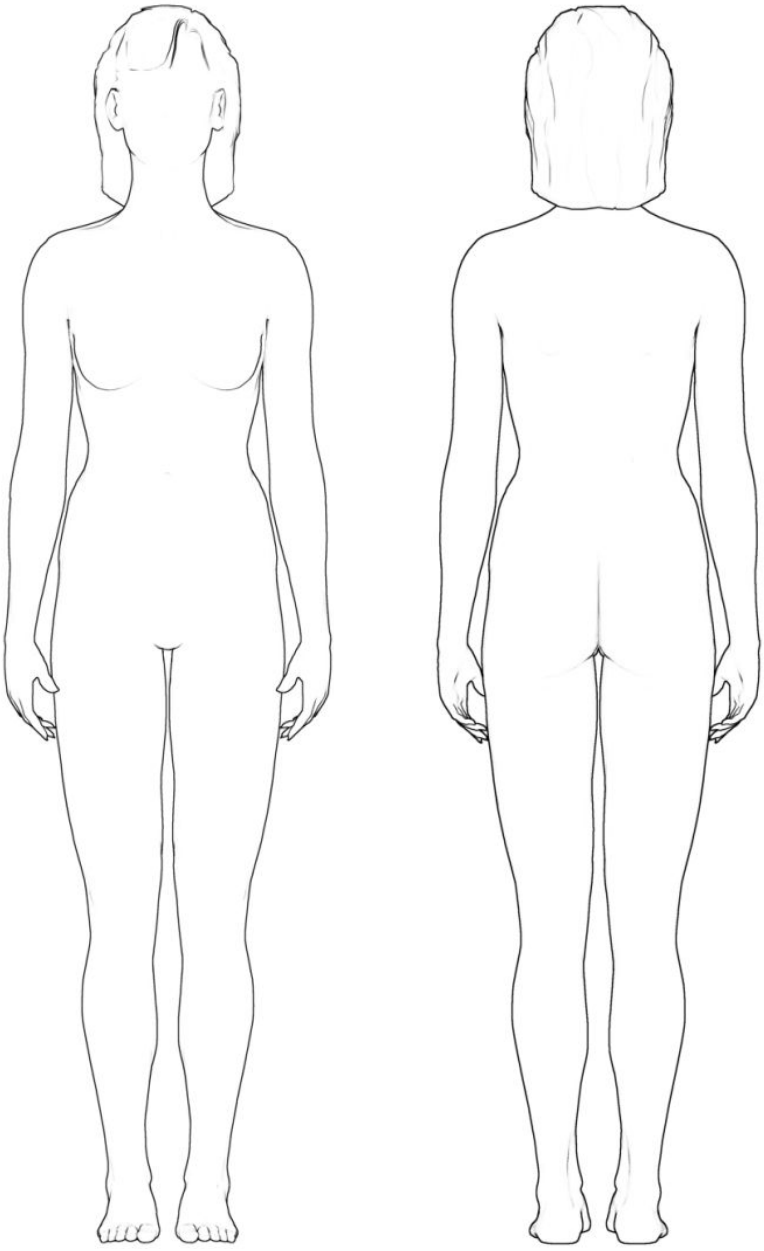
(Skip to the next section if you are not currently experiencing pain.)

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.....I.....I.....I.....I.....I.....I.....I.....I.....I.....10

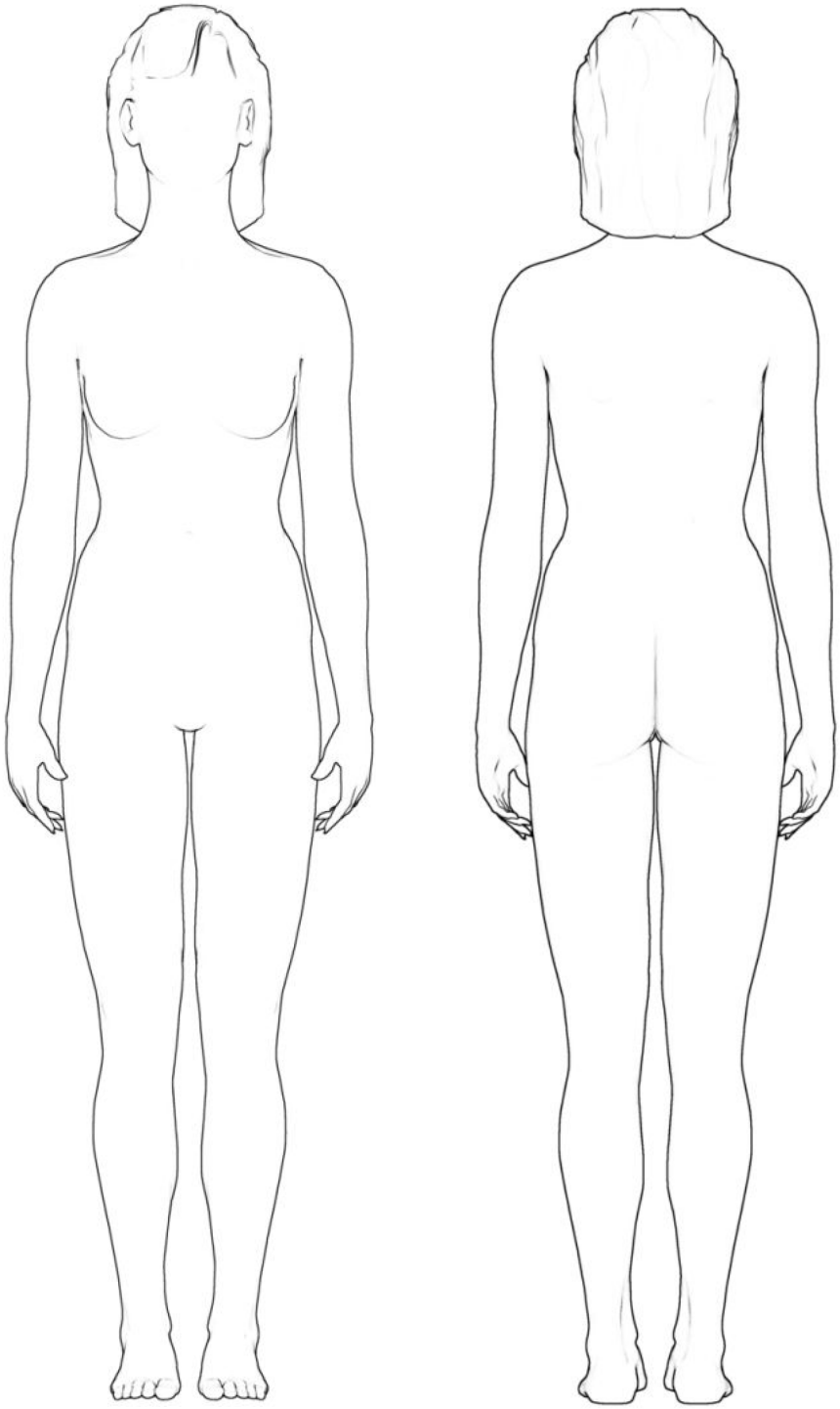
Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

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

MOUTH/THROAT

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

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 with 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

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

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/ankle

SEXUAL/HORMONAL

- ☐ Bleeding between periods
- ☐ Decreased 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 of 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 _____

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

PSYCHOLOGICAL

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

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? **Please bring in any orthotics, braces, or supports!**

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*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?

_____