

Patient Name: \_\_\_\_\_

**Gynecology & Pregnancy (females only):**

- |                           |  |  |                        |
|---------------------------|--|--|------------------------|
| Age of First Menses _____ | <input type="checkbox"/> Irregular periods     | <input type="checkbox"/> PMS               | # of Pregnancies _____ |
| Date of Last Menses _____ | <input type="checkbox"/> Breakthrough bleeding | <input type="checkbox"/> Clots             | # of Births _____      |
| Last Pap Smear _____      | <input type="checkbox"/> Painful periods       | <input type="checkbox"/> Vaginal Sores     | # Miscarriages _____   |
| Menopause _____           | <input type="checkbox"/> Heavy Flow            | <input type="checkbox"/> Vaginal Discharge | # Abortions _____      |
| Hysterectomy _____        | <input type="checkbox"/> Light Flow            | <input type="checkbox"/> Endometriosis     | Difficult births _____ |
| Other _____               | Duration of Flow _____                         | <input type="checkbox"/> Breast Lumps      |                        |

**Neuro-Psychological:**

- |   |  |                                      |   |
|---|--|--------------------------------------|---|
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Migraines   | <input type="checkbox"/> Easily Angered |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Concussion        | <input type="checkbox"/> Headaches   | <input type="checkbox"/> Irritable      |
| <input type="checkbox"/> Loss of Balance      | <input type="checkbox"/> Disorientation    | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Anxiety        |
| <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Poor Memory       | <input type="checkbox"/> Stress      | <input type="checkbox"/> Depression     |

Have you ever received psychiatric treatment? \_\_\_\_\_

Have you ever considered or attempted suicide? \_\_\_\_\_

Any nervous habits? \_\_\_\_\_

Any other problems you would like us to be aware of? \_\_\_\_\_

**Musculo-Skeletal:**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Neck Pain       | <input type="checkbox"/> Hip Pain        | <input type="checkbox"/> Joint Pain     | <input type="checkbox"/> Muscle Spasms   |
| <input type="checkbox"/> Shoulder Pain   | <input type="checkbox"/> Knee Pain       | <input type="checkbox"/> Weak Joints    | <input type="checkbox"/> Muscle Cramping |
| <input type="checkbox"/> Hand/Wrist Pain | <input type="checkbox"/> Foot/Ankle Pain | <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Muscle Soreness |
| <input type="checkbox"/> Back Pain       | <input type="checkbox"/> Scoliosis       | <input type="checkbox"/> Recent Sprains | <input type="checkbox"/> Muscle Weakness |

*Please circle areas of pain or injury and be prepared to describe the type and quality of pain:*

