

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:

