

Gynecology & Pregnancy (females only):

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Irregular Period | <input type="checkbox"/> Duration of flow: _____   | <input type="checkbox"/> # of Pregnancies _____      | <input type="checkbox"/> Difficult Births _____ |
| <input type="checkbox"/> Clots            | <input type="checkbox"/> Painful Periods           | <input type="checkbox"/> # of Births _____           | <input type="checkbox"/> Fertility Problems     |
| <input type="checkbox"/> Light Flow       | <input type="checkbox"/> Age of First Menses _____ | <input type="checkbox"/> # of Miscarriages _____     | <input type="checkbox"/> Breast Lumps           |
| <input type="checkbox"/> Heavy Flow       | <input type="checkbox"/> Date of Last Menses _____ | <input type="checkbox"/> # of Abortions _____        | <input type="checkbox"/> Vaginal Discharge      |
| <input type="checkbox"/> PMS              | <input type="checkbox"/> Last PAP _____            | <input type="checkbox"/> # of Premature Births _____ | <input type="checkbox"/> Vaginal Sores          |

Neuro-Psychological:

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

Have you ever received psychiatric treatment?

Any nervous habits?

Do you smoke? Y N If so, how much? \_\_\_\_\_

Do you consume alcohol? Y N Intake? Mild Moderate Heavy

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

Musculo-Skeletal

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

Please circle areas of pain or injure.

Please be prepared to describe the type and quality of pain.

