Spine Arts Center

Female Health History Questionnaire
(To be completed by patient)

Name _____ **Date** _____

Address _____ Apt.#_____

City_____ State _____ ZIP_____

Home Phone (____) ____-_____ Cell Phone (____) ____-_____

E-mail address: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

REFERRED BY:_____

Chief Complaint(s):

Prescription Drug Usage – Please check if you use any of the following & then list exact names of any medications you are currently using:

☐ Antacids, Zantac, Pepcid, Rolaids, etc.
☐Chemotherapy
☐Radiation
☐Laxatives
☐ Ulcer Medications
☐ Antibiotic/Antifungal
☐Anti-Diabetic/Insulin
☐ Heart Medications
☐Relaxants/Sleep pills
☐Thyroid
☐Antidepressants
☐Aspirin/Acetaminophen
☐ Cortisone/Anti-Inflammation
☐High Blood Pressure Medicine
☐Statins/Cholesterol Lowering Medications
☐ Oral Contraceptives

☐Hormones – If so, what?
When? Dosage?

Please list names of any medications you are currently taking:

Are you allergic to any drugs that you know of? (if so please list names):

Supplement/Vitamin Usage – Please list any supplements/vitamins you are currently taking:

Surgeries, Accidents, Traumas – Please list any surgeries, accidents, or trauma's you have had. Please be sure to include dates as well.

Lifestyle

Dietary Habits: Describe the foods you normally eat:

BREAKFAST: _____

_____

LUNCH: _____

_____

DINNER: _____

_____

SNACKS: _____

_____

Do you consume the following?			**If so, how much?**
1. Soda or carbonated beverages?	YES	NO	_____
2. White flour products?	YES	NO	_____
3. Fried foods?	YES	NO	_____
4. Coffee?	YES	NO	_____
5. Fast foods regularly?	YES	NO	_____
6. Sweets and /or refined carbohydrates?	YES	NO	_____
7. Alcoholic beverages?	YES	NO	_____
8. Any tobacco products?	YES	NO	_____

Are you a vegetarian? YES NO

Are you currently involved in an exercise program? YES NO How often? _____

How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

How do you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

Female Anatomy / Reproductive Health *(to be completed by all women)*

Age at onset of first period: _____ Approximate date of onset: _____

What are you using for contraception at the moment? _____

Have you ever used oral, injected, patch, or ring hormone contraceptives or used *Emergency Contraception ("the day after" pill)?* YES NO
From _____ to _____
Did you suffer from any side effects? YES NO Explain: _____

Are you currently or have you ever used and IUD? YES NO
When? _____ For how long? _____

While under the use of any and all birth control methods, did you experience the following?
Yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc. ***(Please circle and us extra space provided if explanation is needed)***

_____
_____
_____

Are you currently, or have you ever used fertility treatment? YES NO
If yes, please explain. _____
_____

Are you currently, or have you ever used bio-identical hormones, such as DHEA, Pregnenolone, Progesterone, Estrogen, Testosterone, etc.? YES NO

If yes, what hormone(s), dosage and for how long? **Please be specific with dates of use.**

_____
_____

Do you have any history of abnormal Pap Tests? YES NO
If yes, please explain: _____
Please describe any treatment and/or medication for this: _____

Do you have any history of vaginal infections? YES NO
If yes, please describe: _____
Please describe any treatment and/or medications for this: _____

Do you have any history of the following conditions? *(Please circle appropriate answer)*
Ovarian Cysts, Fibrocystic Breasts, Polycystic Ovarian Syndrome (PCOS) Uterine Fibroids, Endometriosis, Lichen Sclerosis, Vulvodynia

Pregnancy History (to be completed by all women, if applicable)

Have you been pregnant before? YES NO
Please list the age(s) of your children:
_____

Please explain important details/complications below:

Number of pregnancies: _____ _____
Number of live births: _____ _____
Number of miscarriages: _____ _____
How many weeks gestation at the time of miscarry? _____ Weeks
Number of premature births: _____ _____
Number of cesarean births: _____ _____
Number of stillbirths: _____ _____
Number of ectopic pregnancies: _____ _____

All menopausal women should now skip to the bottom section of page 5 labeled "menopausal women" and continue on with the remainder of this questionnaire.

Cycling History *(to be completed by all women who have not reached menopause)*

What was the first date of your last menstrual period (LMP)? _____

Have you ever had tubal ligation surgery? YES NO
If so, please list the date and specific details: _____
_____

Counting from the first day of your cycle to the first day of your next cycle, how many days is your current cycle? *(Please circle appropriate answer)*
<20 days 20-30 days 30-40 days 40-50 days >50 days

What is the length of days your menstruation typically lasts? _____

Do you consider your cycle to be regular? YES NO Not Always
Details: _____

What is your typical menstrual flow like? Light Medium Heavy
Details: _____

How many pads and/or tampons *(circle)* do you use on heavy days? _____
During menstruation, do you pass blood clots? YES NO How often? _____

How would you describe your cramping? None Mild Moderate Severe
At what point in your cycle? _____

Cycling History Continued *(to be completed by all women who have not reached menopause)*

Have you noticed any recent changes to your cycle? If yes, explain: _____

Do you experience any unusual or excessive vaginal discharge throughout the month?
YES NO When? _____

Do you ever experience itching or odor in the vaginal area? YES NO
When? _____

Do you experience any breast tenderness? YES NO
If yes, at what point in your cycle? _____ Color? _____

All cycling women should now skip to the bottom section of page 6 labeled "sleep" and continue on with the remainder of this questionnaire

Menopausal Women

What age were you at the onset of menopause? _____ Year of onset? _____
Date of your last menstrual period? _____

Please describe any recent changes and/or symptoms associated with your cycle prior to menopause:
_____
_____
_____
_____

Please list any and all GYN Surgeries:
1._____
2. _____
3. _____
4. _____
5. _____

What was the reason for each surgery?
_____
_____
_____
_____
_____

Please give an in depth explanation of how you perceive your experience transitioning into menopause:
(for example, please list symptoms, emotional changes, thoughts, stressors, etc.)
_____
_____
_____
_____

Are you currently, or have you ever used conventional hormone replacement (HRT)? _____
If yes, please list the name of prescription: _____
What is/was the dosage? _____ For how long? _____

Menopausal Women Continued

Are you currently, or have you ever used bio-identical hormone creams/gels/sublingual, troche, oral?
YES NO
If yes, please list name(s) of each product: _____
What is/was the dosage? _____ For how long? _____

Are you currently, or have you ever used any alternative, complementary, or natural remedies to treat your menopause? YES NO
If yes, please list the name(s) of each product: _____
What is/was the dosage? _____ For how long? _____

Do you currently, or have you, at any point since beginning menopause experienced vaginal spotting or bleeding? YES NO
If yes, when? _____
Treatment: _____

Below please describe your cycle history.

Would you have described your menstruation as: Easy Uncomfortable Difficult Debilitating

What was your typical menstrual flow? Light Medium Heavy

When you were cycling would you describe your cycle as regular? YES NO
If no, please give explanation: _____
_____
_____

Sleep

How well do you sleep?
☐ Well ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Insomnia

What is the average number of hours you most often sleep each night? _____
Do you wake up with night sweats? YES NO

When you wake in the morning do you still feel tired? YES NO
If yes, how often? _____

Do you keep your room completely dark at night? YES NO

New Patient Introduction Form

Dietary intake for 2 days before appointment:

	Day 1:	Day 2:
Breakfast		
Snacks		
Lunch		
Snacks		
Dinner		
Snacks		
Notes:		

Authorization Form:

Regarding the use of Nutrition Reponses Testing

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Spine Arts Center to perform a Nutrition Response Testing health analysis and to develop a natural, complementary, health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or to "cure" any disease.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" any disease including conditions of cancer, AIDS, infections, or any other medical conditions, and that these are not being tested or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, by rather I understand that Nutrition Response Testing is a means by which the body's natural organ response can be used as an aid to determining possible nutritional imbalances, so that safe, natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

_____

Patient/Guardian (Please Print)

_____ Date: _____

Patient/Guardian (Signature)

PLEASE INITIAL NEXT TO EACH NUMBER.

_____ 1. You are expected to keep all appointments as scheduled in order to ensure maximum progress in your case. If for some reason, you cannot make an appointment, we require a minimum 24 hour advanced notice before cancellation or rescheduling. You will need to reschedule that appointment for the SAME week and not fall into the following week. Short notice or no notice may also incur an office visit charge.

_____ 2. Follow-up visits generally take 10 minutes or less. Extended visits, though rarely needed, are charged proportionally. To save time on your visits, write down your questions and let the practitioner know about these at the beginning of the visit. In between visits, it is highly recommended that you take up any questions with the Patient Advocate, either by phone or in person, since there is no charge for time spent with the Patient Advocate.

_____ 3. Fill out your Daily Record of Food Intake form as you eat each meal, snack, etc. between visits. Make it a habit to do it this way and not wait until the end of the day or later. This will ensure accurate information for the practitioner.

_____ 4. TRY NOT to miss any doses of your supplements. Missed doses will slow down improvement and extend the time it takes to complete your program. If you miss a dose, you make it up at a point later in the day. If this happens repeatedly, let the practitioner know so your supplement schedule can be modified.

_____ 5. Please keep in mind that our nutritional products DO NOT cause "side effects" as they are not drugs. Occasionally after starting a nutritional program, you may feel a temporary worsening or even feel "sick." If this occurs, do NOT cancel your appointment. Immediately call the office. Sometimes these "flare-ups" are actually a "Healing Crisis" which indicates your body is starting to heal by throwing off toxins that have been keeping you sick. By fine-tuning your program, we can help you get through these types of situations much more smoothly, if they even occur. When you are not doing well is when it is often most important to come in so we can fine-tune your program and help you correct the underlying cause of the problem more rapidly.

_____ 6. Please consider all the dynamics in your life that could interfere with or prevent you from doing or completing your health improvement program. If you need assistance in working out how to handle any obstacles in your quest for better health, please stay in communication with the patient advocate.

K. Christine Lim, D.C., BCAO
Garry T. Krakos, D.C., BCAO
6120 Brandon Avenue., Suite 203
Springfield, Virginia 22150
(703)644-2222