**A picture containing green, food, sign, device

Description automatically generated**

**INTAKE ASSESSMENT**

This is an *extensive* intake form with many questions to answer. These questions help to put together a picture of your current health, and your answers may help in finding undiagnosed conditions as well as connections between ailments. Some questions may or may not pertain to your health and what you may be experiencing.

Relax, take your time to complete this questionnaire. Provide only information you are comfortable sharing and mark any questions you would prefer to discuss in person.

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pronoun(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Born as: F \_\_\_\_\_ M \_\_\_\_\_ Identify as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (H): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How may we contact you? Check all that apply: Phone\_\_\_ Voicemail Message \_\_\_ Text Message \_\_\_ Email \_\_\_

Would you like to receive emails regarding upcoming events and promotions? Yes \_\_\_\_\_ No \_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel safe in your current living situation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Primary Care Provider? No \_\_\_\_\_\_ Yes \_\_\_\_\_\_ (Complete information below)

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Office Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT CONCERNS**:

Indicate healthcare concerns you would like to address and how long they have been of concern:

(Choose two or three of the most pressing)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you received a diagnosis for these concerns from your Primary Care Provider? No \_\_\_ If yes, explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What other treatments have you previously received or tried to address these concerns?

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How do these concerns impact your life? Do they prevent you from doing what you need and want to do?

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What are your goals regarding these concerns?

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How willing are you to make changes to meet these goals?

\_\_\_\_ Very willing; will do what it takes \_\_\_ Confused/willing; I don’t know what I can do

\_\_\_\_ Willing; I have tried many things already \_\_\_ I don’t think there is anything I can do

Are you receiving care from other healthcare providers for any reason regarding your health? If yes, list the Provider’s name and reason for receiving care:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you interested in having me collaborate with your other healthcare providers to integrate your care?

No \_\_\_ If yes, which one(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any of the following in the past or are you experiencing any of these now?

\_\_\_\_ Blood Thinning

\_\_\_\_ Bleeding Tendency

\_\_\_\_ Vein Condition

\_\_\_\_ Heart Disease

\_\_\_\_ High Blood Pressure

\_\_\_\_ Low Blood Pressure

\_\_\_\_ Pacemaker

\_\_\_\_ Stroke

\_\_\_\_ Nervous Disorder

\_\_\_\_ Seizures

\_\_\_\_ Migraines

\_\_\_\_ Diabetes

\_\_\_\_ Hepatitis

\_\_\_\_ HIV / AIDS

\_\_\_\_ Low Immunity

\_\_\_\_ Thyroid Disease

\_\_\_\_ Rheumatic Fever

\_\_\_\_ Mononucleosis

\_\_\_\_ Cancer

\_\_\_\_ Asthma

\_\_\_\_ Implanted Joints

\_\_\_\_ Bone Stabilizer/Replacement

\_\_\_\_ Other:

List all past surgeries, major illnesses, injuries and hospitalizations with the date or your age (as best as you can remember):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you used antibiotics heavily in the past? List name / type, reason for use, age at time of use:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List current medications, prescriptions, vitamins and supplements you are taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List anything you would like to share about your family health history that may be relevant to your own health:

(especially significant may be diabetes, heart conditions, high blood pressure, cancer, stroke, seizures, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you smoke/vape? No \_\_\_ If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did you begin smoking? \_\_\_\_\_\_\_\_\_\_\_\_ Have you tried to quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? No \_\_\_\_ If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did you begin drinking? \_\_\_\_\_\_\_\_\_\_\_\_ Have you tried to quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you partake of any other drugs? No \_\_\_\_ If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did you begin using drugs? \_\_\_\_\_\_\_\_\_\_ Have you tried to quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all of the following that pertain to you:

**HEART ENERGY**:

\_\_\_\_ Palpitations

\_\_\_\_ Anxiety

\_\_\_\_ Restlessness

\_\_\_\_ Chest pain

\_\_\_\_ Frequent dreams

\_\_\_\_ Nightmares / terrors

\_\_\_\_ Wake unrefreshed

\_\_\_\_ Sores on tongue

\_\_\_\_ Mental confusion/fog

**DAMPNESS**:

\_\_\_\_ Puffiness in face

\_\_\_\_ Chest congestion

\_\_\_\_ Nausea

\_\_\_\_ Snoring

\_\_\_\_ Mental fogginess

\_\_\_\_ Mental sluggishness

\_\_\_\_ Heavy sensation in body

\_\_\_\_ Swollen hands

\_\_\_\_ Swollen feet

**SPLEEN ENERGY**:

\_\_\_\_ Low appetite

\_\_\_\_ Fatigue after eating

\_\_\_\_ Crave sweets

\_\_\_\_ Crave carbohydrates

\_\_\_\_ Gurgling noise in stomach

\_\_\_\_ Abdominal bloating

\_\_\_\_ Gas

\_\_\_\_ Hemorrhoids

\_\_\_\_ Bruise easily

\_\_\_\_ Pensive

\_\_\_\_ Worried

\_\_\_\_ Over-thinking

\_\_\_\_ Abrupt weight gain: how much weight / since when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Abrupt weight loss: how much weight / since when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Prolapsed organ(s) and which one(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STOMACH ENERGY**:

\_\_\_\_ Mouth sores

\_\_\_\_ Bad breath

\_\_\_\_ Hiccups

\_\_\_\_ Belching

\_\_\_\_ Heartburn

\_\_\_\_ Acid regurgitation

\_\_\_\_ Vomiting

\_\_\_\_ Stomach pain

\_\_\_\_ Ulcer

\_\_\_\_ Large Appetite

\_\_\_\_ Bleeding, swollen or

painful gums

\_\_\_\_ Burning sensation after

eating

**LUNG ENERGY**:

\_\_\_\_ Sadness

\_\_\_\_ Melancholy

\_\_\_\_ Cough

\_\_\_\_ Dry mouth

\_\_\_\_ Dry throat

\_\_\_\_ Dry nose

\_\_\_\_ Nasal discharge

\_\_\_\_ Nose bleeds

\_\_\_\_ Sneezing

\_\_\_\_ Sinus congestion

\_\_\_\_ Sore throat

\_\_\_\_ Alternating chills / fever

\_\_\_\_ Allergies: to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIVER / GALLBLADDER ENERGY**:

\_\_\_\_ Depression

\_\_\_\_ Convulsions

\_\_\_\_ Numbness

\_\_\_\_ Seizures

\_\_\_\_ Muscle spasms

\_\_\_\_ Skin rashes

\_\_\_\_ Anger easily

\_\_\_\_ Lump in throat

\_\_\_\_ Recreational drugs

\_\_\_\_ Tingling sensation

\_\_\_\_ Neck / shoulder tension

\_\_\_\_ Bitter taste in mouth

\_\_\_\_ Muscle cramps / twitching

\_\_\_\_ High pitch ringing in ears

\_\_\_\_ Gallstones (history or

current)

\_\_\_\_ Temple / eye headaches

\_\_\_\_ Frustration and / or

irritability

\_\_\_\_ Drinking alcohol

\_\_\_\_ Trouble adapting to

change

\_\_\_\_ Alternating diarrhea and

constipation

**KIDNEY / BLADDER ENERGY**:

\_\_\_\_ Sore knees

\_\_\_\_ Weak knees

\_\_\_\_ Fear

\_\_\_\_ Kidney stones

\_\_\_\_ Easily startled

\_\_\_\_ Low back pain

\_\_\_\_ Memory problems

\_\_\_\_ Excessive hair loss

\_\_\_\_ Easily broken bones

\_\_\_\_ Osteoporosis

\_\_\_\_ Osteopenia

\_\_\_\_ Low-pitched ringing in

ears

\_\_\_\_ Tooth problems

**OTHER ENERGY ISSUES**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you exercise regularly? No \_\_\_\_ If yes, describe what you do and how often:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Your current emotional stress scale: (Check one, with “1” being lowest and “10” being highest)

1 \_\_\_\_\_\_ 2 \_\_\_\_\_\_ 3 \_\_\_\_\_\_ 4 \_\_\_\_\_\_ 5 \_\_\_\_\_\_ 6 \_\_\_\_\_\_ 7 \_\_\_\_\_\_ 8 \_\_\_\_\_\_ 9 \_\_\_\_\_\_ 10 \_\_\_\_\_\_

What do you typically do to relieve stress / to relax / take time for yourself?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How many hours do you usually sleep per night? \_\_\_\_\_\_\_\_\_\_\_\_\_ When do you go to bed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do wake frequently during the night? Yes \_\_\_ No \_\_\_ Do you wake feeling refreshed? Yes \_\_\_ No \_\_\_

Current Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight one year ago: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the most you have ever weighed? \_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you have a bowel movement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink coffee? No \_\_\_ If yes, how much and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink caffeinated tea? No \_\_\_ If yes, how much and often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink soda? No \_\_\_\_ If yes: Regular \_\_\_\_\_\_ Diet \_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have regular eating habits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat while engaged in other activities / occupations? No \_\_\_\_ If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat more when feeling anxious or stressed or depressed? No \_\_\_\_ Yes \_\_\_\_\_

Do you experience sudden drops in energy? No \_\_\_ If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***ANATOMICALLY MALE***: (Check all that apply)

\_\_\_\_\_ Swollen testes \_\_\_\_\_ Testicular pain \_\_\_\_\_ Impotence \_\_\_\_ Premature Ejaculation

\_\_\_\_\_ Trouble with urination (frequency, hesitation, pain, dribbling) \_\_\_\_ Coldness / Numbness in genitalia

Are you currently sexually active? No \_\_\_\_\_ If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a vasectomy? No \_\_\_\_ If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually Transmitted Disease(s): (Past or present)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\* IF NOT ANATOMICALLY FEMALE, SKIP TO END OF NEXT PAGE TO DATE AND SIGN DOCUMENT

***ANATOMICALLY FEMALE***: (Check all that apply)

**SEXUAL HEALTH**:

Are you currently sexually active? No \_\_\_\_ If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience pain or discomfort during intercourse? No \_\_\_\_ If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually Transmitted Disease(s): (Past or present)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENSTRUATION**:

Age of first menstruation: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Periods generally last how many days? \_\_\_\_\_\_\_\_\_\_\_ and occur every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ days

Bleeding during periods tends to be: Light \_\_\_\_\_ Moderate \_\_\_\_ Heavy \_\_\_\_\_ Extremely Heavy \_\_\_\_\_

Check any of the following you may experience during your period:

Nausea \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Vomiting \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Light-headedness \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Headaches \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Migraines \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Anxiety \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Depression \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Irritability \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Weepiness / Crying \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Breast Tenderness \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Water Retention \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

Food cravings \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

For which foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain / Cramping \_\_\_\_ Before \_\_\_\_ During \_\_\_\_ After

For pain: What type? Dull \_\_\_ Sharp \_\_\_\_ Lasting how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENOPAUSE**:

Age at menopause: (when periods have stopped for one year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hysterectomy? No\_\_\_\_ if yes, at what age? \_\_\_\_\_\_\_\_\_\_\_\_ Full: \_\_\_\_\_\_\_\_\_\_\_\_ Partial: \_\_\_\_\_\_\_\_

If currently peri-menopausal or menopausal, are you taking Hormone Replacement Therapy? No \_\_\_ Yes \_\_\_\_

List symptoms and concerns:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PREGNANCY**: (Use list for answers)

Number of Pregnancy Your age at time of pregnancy Resulting in live birth (Y/N) Vaginal or Caesarean

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**PRINTED PATIENT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_