GET WELL
CHIROPRACTIC

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M / F Marital Status: _____

Address: _____

Home Phone #: _____ Cell #: _____

Email Address: _____

Chief Complaint(s): _____

_____

_____

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

- ❑ Pain Relievers: Aspirin, Tylenol, Vicodin, Celebrex, etc.
- ❑ Anti-inflammatory: Ibuprofen, Motrin, Aleve, Diclofenac, etc.
- ❑ Antacids: Zantac, Rolaids, Prilosec, Nexium, etc.
- ❑ Ulcer Medications
- ❑ Laxatives
- ❑ Relaxants/Sleep Aids
- ❑ Cholesterol/Heart Medication
- ❑ High Blood Pressure Medication
- ❑ Oral Contraceptives
- ❑ Hormones—if so, what? _____ When? _____ Dosage? _____
- ❑ Antibiotics
- ❑ Antifungal
- ❑ Anti-diabetic/Insulin
- ❑ Antidepressants
- ❑ Antianxiety Medication
- ❑ Thyroid Medication
- ❑ Chemotherapy
- ❑ Radiation

Please list the names of any medications you are currently taking: _____

_____

_____

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

_____

_____

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

_____

_____

Have you had any body parts or organs removed? (Please list): _____

_____

_____

Lifestyle

Dietary Habits: Describe the food that 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 food 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 programs?	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		

Males Only

Have you had a vasectomy? YES NO When? _____

Reverse vasectomy? YES NO When? _____

Have you experienced any symptoms related to the vasectomy? YES NO

If so, please explain: _____

_____

Do you have a history of prostate problems? YES NO

If so, please explain: _____

_____

When was your last prostate exam? _____

What were your most recent PSA results? _____ Date: _____

Does your bladder always feel full?	YES	NO	SOMETIMES
Do you experience inconsistent pressure or pain during urination?	YES	NO	SOMETIMES
Does ejaculation cause pain?	YES	NO	SOMETIMES
Do you experience a low sex drive?	YES	NO	SOMETIMES
Do you have premature ejaculation?	YES	NO	SOMETIMES

All men completing this form should now skip to the bottom section of page 6 labeled "sleep" and continue on with the remainder of this questionnaire.

Females Only—Reproductive Health History (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 "morning after" pill)? YES NO From: _____ to _____

Did you suffer from any side effects? YES NO Explain: _____

Are you currently or have you ever used an 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 swings, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc. **(Please circle and use extra space to provide explanation if needed.)**

_____

_____

_____

Are you currently, or have you ever used fertility treatment? YES NO

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

If yes, what hormones, dosage, and for how long? **Please be specific with date 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 the following conditions? (Please circle appropriate answer)

Ovarian Cysts, Fibrocystic Breasts, Polycystic Ovarian Syndrome (PCOS), Uterine Fibroids, Endometriosis, LichenSclerosis, Vulvodynia

If yes, please explain: _____

_____

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

Have you been pregnant before? YES NO (if no, skip to next section)

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? _____

Number of premature births: _____ _____

Number of cesarean births: _____ _____

Number of still births: _____ _____

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? _____

Have you ever had a 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 menstruation flow like? LIGHT MEDIUM HEAVY

Details: _____

How many pads and/or tampons (circle) do you use on heavy days? _____

During menstruation, do you pass blot clots? YES NO How Often? _____

How would you describe your cramping? NONE MILD MODERATE SEVERE

At what point do you experience cramping in your cycle? _____

Cycling History (continued)

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

During menstruation do you experience any vaginal discharge? YES NO

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

Do you experience any breast tenderness? NONE MILD MODERATE SEVERE

If yes, at what point in your cycle? _____

Do you have nipple discharge at any point in your cycle? 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? _____

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

_____

_____

Please list any and all GYN surgeries:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

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 the prescription: _____

What was the dosage? _____ How long? _____

Menopausal Women (continued)

Are you currently, or have you ever, used bio-identical hormone creams/gels, sublingual, troche, or oral?

YES NO If yes, please list the name of each product: _____

_____

What 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 of each product: _____

_____

What 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, explain: _____

_____

Treatment: _____

Below please describe your cycle history

When you were cycling, would you have described your menstruations as:

Easy Uncomfortable Difficult Debilitating

What was your typical menstrual flow? Light Medium Heavy

When you were cycling, would you have described your cycle as regular? YES NO

If no, please give explanation: _____

In the past, if you have ever received any type of "treatment" for any cycle issues, would you please explain?:

_____

_____

_____

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

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