CLIENT HEALTH HISTORY
FOR WOMEN ONLY

Your Menstrual Pattern:

_____ Painful periods
_____ Late, early, or irregular
_____ Dark, thick blood at onset or end of menstruation
_____ Dizziness with period
_____ Headache or migraine with period
_____ Excessive bleeding (more than one pad per hour)
_____ Blood clots during menstruation
_____ PMS/Depression with or before period
_____ Failure to ovulate regularly
_____ Painful ovulation
_____ Bloating or water retention with period

Do you experience heaviness in the lower pelvis **as menses begin**? _____
Do you experience heaviness in the lower pelvis **during ovulation**? _____
How many days does your period last? ____ Do you experience NO periods at all?_____
Explain_____
Have you experienced a period every two weeks within the past few years?_____
Have you taken hormone replacement therapy? ____ If so, for how long?_____

Check other signs or symptoms that apply:

Varicose veins of the legs ___
Numb legs and feet especially when standing still ___
Constipation ___
Low back ache ___
Cervical polyps ___
Uterine polyps ___
Uterine fibroids ___
Uterine infections ___
Frequent urination ___
Vaginal discharge ___ (color/how often?) _____
Vaginal yeast conditions/vaginitis ___
Chronic miscarriages ___
Premature deliveries ___
Weak newborn infants ___
False pregnancies ___
Difficult pregnancy, "incompetent" uterus ___
Sexually transmitted disease ___

Tired weak legs ___
Sore heels when walking ___
Painful intercourse ___
Hot flashes ___
Mood swings ___
Memory loss ___
Depression ___
Difficult menopause ___
Bladder infections ___
Insomnia ___
Fatigue ___
Spotting ___
Pelvic inflammation ___
Ovarian or breast cysts ___
Endometriosis ___
Endometritis ___

Dry vagina with or without menopause _____
Cancer of the cervix, uterus, bladder, or lower bowel (circle) _____
List any other symptoms not included on list: _____
How many pregnancies have you had? _____ Number of deliveries? _____
Date(s) of deliveries _____ How many children? _____
Were there any complications? _____
What was pregnancy like for you?_____
labor? _____
delivery?_____
Did you nurse your babies? _____
If so, what was your impression of that experience?_____
Have you had any miscarriages? _____ Have you had any abortions?_____
If so, how many and when_____
What medications did *your mother* take when she was pregnant with *you*?_____

Do any of the **women on your mother's side of the family** suffer from any of the following:

Fertility issues _____ Menstrual problems _____ Difficult childbirth _____
Difficult menopause_____ Cancer _____ Heart trouble _____

Are you currently pregnant?_____ Are you hoping to become pregnant in the future?_____
Do you now or have you ever had fertility challenges? _____
Are you now or have you ever taken birth control pills? _____
When and for how long? _____
If any, what type of birth control methods do you *currently* use? _____
Are you presently or have you recently been under a doctor's care for gynecological problems?
Explain _____

Please list any serious falls or accidents in childhood or as an adult especially those that involved your tailbone, back, head, or any whiplash – please explain: _____
_____

Rate your interest in sex: High ____ Moderate ____ Low ____ None ____
Do you have difficulty achieving orgasms? _____ Explain _____
Were you ever raped? _____ At what age did this occur? _____
Are you a survivor of incest? _____ Have you undergone counseling for rape or incest? _____
What was that like for you? Did it help? _____

SUPPLEMENTS

Please list any supplements, herbs, vitamins, or natural products you are presently taking:

_____

_____