Holden Chiropractic LLC
Dr. Holly Holden

Nutrition Patient Questionnaire

Patient#_____ Date _____

Classification_____ SS#_____

Name_____ Date of Birth _____

Address_____ City/State/Zip___ _____

Email_____

Telephone: Home_____ Work_____

Place of Employment_____ Occupation _____

Married _____ Single _____ Divorced _____ Widow(er) _____ # of Children_____

Spouse's Name_____ Place of Employment _____

In Case of Emergency, who should we contact?
Name_____ Phone_____ Relationship _____

How did you hear about our office? _____

We will provide a receipt for you to submit to your insurance. You are responsible for payment in full at the time of service.
** I clearly understand that all services rendered me are my responsibility and payment is expected at the time of service.
Patient's Signature_____ Date _____

If under 18 years of age, parent or guardian's signature _____

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."*
A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.
Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.
Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.
Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above:

Signature _____ Date _____

HIPAA Agreement

Whole Health Center will receive health information that is protected as defined by the regulations promulgated under HIPAA (the "HIPAA privacy rule") in order to provide chiropractic care on behalf of the patient. Therefore, the parties agree as follows:

1. Whole Health Center will not use and/or disclose, and will require his agents and subcontractors to whom he provides personal health information (PHI) as permitted to agree not to use and/or disclose PHI except (1) as necessary to provide the services described in the Certification and Assignment; (2) as otherwise permitted or required by these HIPAA Privacy Provisions; (3) as required or permitted by law; (4) for the proper management and administration of his business.

2. Whole Health Center will use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement.

3. Whole Health Center will report to patient any use or disclosure of PHI not provided for by this Agreement of which he becomes aware.

4. Whole Health Center will ensure that any agent of his, including subcontractors to whom he provides PHI received from or created by Whole Health Center on behalf of patient, agrees to the same restrictions and commitments that apply to Whole Health Center with respect to such information.

5. Whole Health Center will make available PHI to the extent required under 45 C.F.R. and 164.524, which describes the requirements applicable to an individual's request for access by the PHI relating to the individual.

6. Upon patient's request, Whole Health Center will make available PHI relating to a patient available to patient for amendment and incorporate any amendments or corrections to PHI when notified to do so in writing by patient in accordance with the provisions of 45 C.F.R. and 164.526 as finalized.

7. Whole Health Center will make available PHI to the extent required to provide an accounting of disclosures in accordance with 45 C.F.R. and 164.528, which describes the requirements applicable to an individual's request for an accounting of disclosures of PHI relating to the individual.

8. Whole Health Center agrees to make his internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Whole Health Center on behalf of patient available to the Secretary of the Department of Health and Human Services for the purpose of determining patient compliance with the use and disclosure of PHI.

9. These Terms and Conditions cannot be amended except by the mutual written agreement of Whole Health Center and patient.

In the event any provision of these HIPAA Privacy Provisions is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions in this Agreement will remain in full force and effect. In addition, in the event a patient believes in good faith that any of these provisions fails to comply with the then-current requirements of the HIPAA Privacy Rule, such party so shall notify the other party in writing. For a period of up to 30 days, the parties shall address in good faith such concern and shall amend the terms of this Agreement, if necessary to bring it into compliance.

Signature: _____ Date: _____

(Signature of patient or legal guardian)

Patient's Name: _____

(Print Name)

Whole Health Center Financial Policy for Patient Care Services

Whole Health Center wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our financial policy. To help us help you, please:

1.) Provide us with accurate and updated information on yourself.
2.) Pay at the time of service for your entire balance.
3.) Discuss your account balance only with the front office staff. It is important for practitioners to be allowed to provide patient care. If the front office staff cannot help you, do not hesitate to contact the office manager.

Whole Health Center and its providers accept worker's compensation and auto accident insurance. We require that a lien signed by the patient and any attorneys is on file when applicable. WHC and its providers are willing to extend the expectation of payment within 60 days for worker's compensation and auto accident insurance when Med-Pay is not available.

If you prefer that we do not file insurance claims for you, you may pay the "Cash at Time of Service" discounted rate and send the claim to your insurance carrier. If you choose to submit your own claims, we will provide you with a superbill, but cannot assist you in filing your claims.

Cancellation Policy:
In order to provide you with the best care, please arrive 10 minutes prior to your appointment – late arrival may result in cancellation. We require 24 hours' notice of cancellation or you may be charged a fee. Please remember that failure to appear for your appointment prevents others from receiving care.

Finance Charges:
Failure to pay for services and products provided by our office will result in a finance charge. If we need to forward your account to a collection agency for further legal action, you will be responsible for the entire balance on your account plus any collection fees.

NSF Charges:
We charge a NSF charge if any payment is returned due to insufficient funds. If payment is returned then we are authorized to charge your credit card on file for the balance owed plus the NSF Charge.

Permission to Charge Credit Card on File for Past due balances:
We will always attempt to contact you regarding past due invoices. However, after repeated attempts to collect, we will charge your credit card on file. Your signature on the line below indicates that you understand you are agreeing to allow Whole Health Center to charge your credit card for a past due balance if your invoice balance lapses past the due date. If we do not have a credit card on file, we will forward your account to collections for the entire balance on your account plus any collection fees.

_____ _____

Responsible Party or Authorized Person Signature Date

PATIENT SYMPTOM SURVEY

DATE_____

PATIENT'S NAME_____ **DOB** ___/___/_____

WEIGHT_____ **HEIGHT**_____ **BLOOD PRESSURE**_____ **PULSE**_____ **O_2**_____

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time...

Primary Complaints

090 ☐ General Good Health
091 ☐ Desires Nutritional & Metabolic Analysis
001 ☐ Skin Disorder 692.9
002 ☐ Acne 706.1
003 ☐ Psoriasis 696.1
004 ☐ Urticaria (Hives) 708.9
005 ☐ ADD/ADHD 314.00/314.01
006 ☐ Allergies, Unspecified 477.9
007 ☐ Allergic Rhinitis from food 477.1
008 ☐ Sinusitis 461.9
009 ☐ Alzheimer's 331.0
010 ☐ Poor Concentration/Memory 310.1
011 ☐ Parkinson's Disease 332.0
012 ☐ Anemia 285.9
013 ☐ Arthritic Disorder 716.90
014 ☐ Osteoporosis 733.00
015 ☐ Asthma 493.90
016 ☐ Emphysema 492.8
017 ☐ Cancer
- 018 ☐Breast 174.9female 175.9male
- 019 ☐Prostate 185
- 020 ☐Lung 162.9
- 021 ☐Colon and Rectal 153.9
- 022 ☐Skin 173.9
- 023 ☐Leukemia w/o remission 208.90 Leukemia w/ remission 208.91
- 024 ☐Lymphoma, malignant 202.8
- 025 ☐Brain Tumor, malignant 191.9

027 ☐ Anxiety Disorder 300.00
028 ☐ Autism 299.00
033 ☐ Edema 782.3
034 ☐ Eczema 692.9
035 ☐ Chronic Fatigue 780.71
036 ☐ Circulatory Disorder 459.9
037 ☐ Heart Disease 429.9
038 ☐ High Cholesterol 272.0
039 ☐ High Blood Pressure 401.9
040 ☐ Low Blood Pressure 458.9
041 ☐ Tachycardia (High Heart Rate) 785.00
042 ☐ Numbness 782.0
043 ☐ Constipation 564.0
044 ☐ Indigestion 536.8
045 ☐ Ulcerative Colitis 556.9
046 ☐ Depression 311
047 ☐ Diabetes Mellitus 250.0
030 ☐ Diabetes Type I 250.01
031 ☐ Diabetes Type II 250.02
029 ☐ Hyperglycemia [high blood sugar] 790.29
048 ☐ Hypoglycemia [low blood sugar] 251.2
049 ☐ Dizziness/Balance Problem 780.4
050 ☐ Ear Infection 381.4
051 ☐ Epstein Barr 075
052 ☐ Eye Problems 379.91
053 ☐Cataracts 366.9
054 ☐Glaucoma 365.9
055 ☐Macular Degeneration 362.50
056 ☐ Fever 780.6
057 ☐ Fibromyalgia 729.1
058 ☐ Gallbladder Disorder 575.9
059 ☐ Gout 274.9
060 ☐ Headaches 784.0
061 ☐ Hearing Loss 389.9
062 ☐ Infertility, male 606.9
064 ☐ Liver Disease 571.9
- 065 ☐Hepatitis 573.3
- 066 ☐Hepatitis B 070.30
- 067 ☐Hepatitis C 070.51

068 ☐ Kidney Disorder 593.9 or Bladder Disorder 596.9
063 ☐ Prostate Disorder 602.9
069 ☐ Hyperthyroidism 242.90
070 ☐ Hypothyroidism 244.9
071 ☐ Systemic Lupus 710.0
072 ☐ Infertility, female 628.9
073 ☐ Interstitial Cystitis 595.1
074 ☐ Irregular Menstrual Cycle 626.4
075 ☐ Menopausal Symptoms 627.2
076 ☐ Hot Flashes 627.2
077 ☐ Mental Disorder 300.9
078 ☐ Insomnia 780.52
079 ☐ Mouth/Throat/Tongue
080 ☐ Canker Sores 528.2
081 ☐ Overweight 278.02
082 ☐ Underweight 783.22
083 ☐ Sexual Disorder 302.89
084 ☐ Spinal Problems 724.9
085 ☐ Obesity 278.00
086 ☐ GERD 530.81
087 ☐ HIV 042
088 ☐ Crohn's Disease 555.9
089 ☐ Irritable Bowel Syndrome 564.1
092 ☐ Normal Pregnancy v22.2
**only applicable if *currently* pregnant
093 ☐ Shingles 053.9
140 ☐ Migraines 346.90
141 ☐ Rheumatoid Arthritis 714.0
142 ☐ Non-Systemic Lupus 695.4
143 ☐ Multiple Sclerosis 340
144 ☐ ALS (Lou Gerigs) 335.20
145 ☐ Polymyalgia Rheumatica 725
146 ☐ Scleroderma 710.1
171 ☐ Goiter 240.9
178 ☐ Raynaud's Syndrome 443.8
179 ☐ Hemochromatosis 275.0
180 ☐ Thalassemia 282.49
181 ☐ Brain aneurysm 431

If necessary, please state your most significant concern...

_____

_____

General Health

100 ☐ Fingernail base is pink
101 ☐ Fingernail base is purple
102 ☐ Fingernails have ridges or white spots
103 ☐ Fingernails are soft
104 ☐ Fingernails are splitting
105 ☐ Fingernails peel
106 ☐ Pale fingernail beds
107 ☐ Blacks out easily
108 ☐ Balance problems
109 ☐ Difficulty walking
110 ☐ Has tattoos
111 ☐ Brittle hair
112 ☐ Dry hair
113 ☐ Thin hair
114 ☐ Hair loss
115 ☐ Drinks alcoholic beverages daily
116 ☐ Drinks less than 8 glasses of water per day
117 ☐ Currently on Chemotherapy
118 ☐ Currently on radiation treatment
119 ☐ Had chemotherapy in the past
120 ☐ Has had radiation treatments in the past
121 ☐ Gained over 20 lbs in the last 12 months
122 ☐ Somewhat Overweight
123 ☐ Somewhat Underweight
124 ☐ Unexplained loss of >20lbs in last 4 months
125 ☐ Energy level is worse than it was 5 years ago
127 ☐ Sleeps less than 6 hours per night
128 ☐ Unable to recall dreams the next day
129 ☐ Sensitive to chemicals, paint, fumes, cologne
130 ☐ Had blood transfusion in the past
131 ☐ Had transplant in the past
138 ☐ Takes anti-rejection drugs
132 ☐ Had a major accident or injury
137 ☐ Sleep Apnea
139 ☐ Toxic chemical exposure
175 ☐ Has been out of the country recently
176 ☐ Had childhood vaccines
177 ☐ Had a vaccine in the last 12 months
147 ☐ Had a flu shot last year
182 ☐ Had a pneumonia vaccine last year
183 ☐ Had a Hepatitis B vaccine in the last 2 years.

Has a family history of:

184 ☐ Cancer
185 ☐ Heart Disease
186 ☐ Diabetes
187 ☐ Alcoholism
188 ☐ Depression
189 ☐ Obesity

Lifestyle & Environment

Do you use? ☐ Well Water ☐ City Water Filtered? ☐ Yes ☐ No Filter Type? _____

What kind of pipes are in your home? ☐ Steel ☐ CPVC ☐ Copper ☐ Pex ☐ Other _____

What year was your home built? _____ Any renovations in the past year? _____

Do you use chlorine bleach or other heavy duty cleaners in your home/work? ☐ Yes ☐ No

Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry? ☐ Yes ☐ No

Explain: _____

Have you ever worked around industrial solvents, chemicals or pesticides? ☐ Yes ☐ No

Explain: _____

380 ☐ Drinks beverages from a can
370 ☐ Drinks alcohol
371 ☐ Drinks caffeinated coffee
372 ☐ Drinks caffeinated pop/soda
373 ☐ Drinks caffeinated tea
374 ☐ Drinks decaffeinated coffee
375 ☐ Drinks decaffeinated pop/soda
376 ☐ Drinks decaffeinated tea
377 ☐ Drinks >3 cups of coffee daily
378 ☐ Drinks >3 cups of tea per day
388 ☐ Drinks diet pop/soda
379 ☐ Drinks >1 pop/sodas per day

I had 4 alcoholic drinks in one day:

172 ☐ never
173 ☐ more than 3 months ago
174 ☐ less than 3 months ago

381 ☐ Has >5 alcoholic drinks/week
391 ☐ Craves sugar / starches
382 ☐ Currently smokes
383 ☐ Quit smoking in last 5 years
384 ☐ Smoked for >5 years
385 ☐ Smokes >1 pack per day
126 ☐ Rarely exercises
133 ☐ Regularly exercises
386 ☐ Takes Vitamins
134 ☐ Vegetarian
135 ☐ Eats no red meat
136 ☐ Eats no meat, no dairy
387 ☐ Frequent use of artificial sweeteners
389 ☐ Anorexia
390 ☐ Bulimic

Surgeries

700 ☐ Tonsillectomy and/or Adenoids
701 ☐ Appendix
702 ☐ Gallbladder
703 ☐ Thyroid
704 ☐ Hysterectomy, complete
705 ☐ Hysterectomy, partial
706 ☐ Tubal ligation
707 ☐ Breast implants
708 ☐ Cancer
709 ☐ Coronary by-pass
710 ☐ Spinal surgery
711 ☐ Extremity surgery
712 ☐ Hip replacement
713 ☐ Knee replacement
714 ☐ Splenectomy
715 ☐ Radiated thyroid
716 ☐ Cataract surgery
717 ☐ Hemorroidectomy
718 ☐ Bariatric/Weight loss
Type: _____

Gastrointestinal

265 ☐ 4-5 bowel movements per week
266 ☐ 3 or less bowel movements per week
267 ☐ 6 or more bowel movements per week
268 ☐ Black tarry stools
269 ☐ Pale or yellow colored stool
270 ☐ Blood stools
271 ☐ Constipation
272 ☐ Hemorrhoids
273 ☐ Loose bowel movements
274 ☐ Frequent diarrhea
275 ☐ Frequent nausea
276 ☐ Frequent vomiting
277 ☐ Abdominal gas
278 ☐ Belching and burping after eating
279 ☐ Bloated after eating
280 ☐ Severe abdominal pains
281 ☐ Stomach ulcers
282 ☐ Uses digestive aids
283 ☐ Uses laxatives
284 ☐ Immediate indigestion upon eating
285 ☐ Indigestion in 2 hours or more after meals
286 ☐ Indigestion within 1 hour after meals
287 ☐ Difficulty swallowing
288 ☐ Eating relieves fatigue
289 ☐ Eats when nervous
290 ☐ Excessive hunger
291 ☐ Poor appetite
292 ☐ Experiences fainting spells when hungry
293 ☐ Feels shaky when hungry
294 ☐ Frequently drowsy after eating a meal
295 ☐ Gall bladder disease
296 ☐ Has had intestinal worms
297 ☐ Reflux/Hiatal hernia
298 ☐ Liver disease
299 ☐ Irritable Bowel Syndrome
300 ☐ Diverticulitis
301 ☐ Diverticulosis

Respiratory

485 ☐ Catches severe colds
486 ☐ Chronic chest condition
487 ☐ Chronic cough
488 ☐ Constant runny nose
489 ☐ COPD
490 ☐ Difficulty breathing
491 ☐ Frequent colds
492 ☐ Frequent nose bleeds
493 ☐ Frequent sinus infections
494 ☐ Frequent stuffy nose
495 ☐ Hay fever
496 ☐ Nasal polyps
497 ☐ Night sweats
498 ☐ Post nasal drip
499 ☐ Sneezing spells
500 ☐ Spits up blood
501 ☐ Spits up phlegm
502 ☐ Wheezes

Mouth and Throat

400 ☐ Bad breath
401 ☐ Bitter taste in the mouth in the morning
402 ☐ Dry mouth
403 ☐ Excessive saliva
404 ☐ Sores or cracks in the corners of the mouth
405 ☐ Glands often swell
406 ☐ Frequent canker sores
407 ☐ Frequent fever blisters
408 ☐ Frequent sore throats
409 ☐ Frequently has a sore tongue
410 ☐ Sore gums
411 ☐ Swollen gums
412 ☐ Swollen tongue
413 ☐ Tongue burns
414 ☐ Tongue has grooves or fissures
415 ☐ Tongue is coated
416 ☐ Gums bleed when brushing teeth
417 ☐ Toothaches
418 ☐ Amalgam dental fillings
420 ☐ Other dental fillings (gold, composite, etc)
419 ☐ Has had root canal(s)

Endocrine

245 ☐ Coarse hair
246 ☐ Coarse skin
247 ☐ Diabetic
248 ☐ Excessive thirst
249 ☐ Frequently feels cold
250 ☐ Frequently feels hot
251 ☐ Gets lightheaded when standing quickly
252 ☐ Heals slowly
253 ☐ Unusually jumpy or nervous
254 ☐ Unusually tired most of the time

Cardiovascular

190 ☐ Cold feet
191 ☐ Cold hands
192 ☐ Experiences shortness of breath while sitting still
193 ☐ Heart skips beats
194 ☐ Tendency of High blood pressure
195 ☐ Leg cramps during bedtime
196 ☐ Leg cramps during daytime
197 ☐ Low blood pressure at times
198 ☐ Pain in leg/hips when walking
199 ☐ Frequent swollen ankles
200 ☐ Pains in the heart or chest
201 ☐ Spells of rapid heart rate
202 ☐ Troubled with blood clots
203 ☐ Unusually slow pulse rate
204 ☐ Varicose veins
205 ☐ Heart palpitations

Skin

520 ☐ Bruises easily
521 ☐ Excessive perspiration
522 ☐ Frequent goose bumps
523 ☐ Has acne
524 ☐ Has Psoriasis
525 ☐ Hives
526 ☐ Itchy skin
527 ☐ Problems with Eczema
528 ☐ Has moles which are changing in size and/or color
530 ☐ Skin is rough, especially on the back of the arms
529 ☐ Skin eruptions
531 ☐ Skin is tender
532 ☐ Sores that heal slowly
533 ☐ Troubled with boils
534 ☐ Dry skin

Ears

220 ☐ Discharge from ears
221 ☐ Hard of hearing
222 ☐ Punctured ear drum
223 ☐ Recurrent ear infection
224 ☐ Ringing or noises in the ears
225 ☐ Tinnitus

Eyes

320 ☐ Bloodshot eyes
321 ☐ Blurred vision
322 ☐ Cross eyes
323 ☐ Eye pain
324 ☐ Eyes feel gritty
325 ☐ Eyes watery
326 ☐ Mild Glaucoma
327 ☐ Far sighted
328 ☐ Developing cataracts
329 ☐ Mild Macular degeneration
330 ☐ Itchy eyes
331 ☐ Near sighted
332 ☐ Dry Eyes

Feet

350 ☐ Corns
351 ☐ Frequent foot cramps
352 ☐ Heel spurs
353 ☐ Painful feet
354 ☐ Plantar warts
355 ☐ Swelling in the feet and/or ankles
356 ☐ Plantar fasciitis
357 ☐ Fungal Infection

Neuromuscular

440 ☐ Bites nails
441 ☐ Frequent muscle soreness
442 ☐ Muscle spasms
443 ☐ Muscle weakness
444 ☐ Tremors
445 ☐ Frequent headaches
446 ☐ Often dizzy
447 ☐ Frequently feels faint
448 ☐ Has Epilepsy
449 ☐ Has motion sickness
450 ☐ Has Osteoarthritis
451 ☐ Has Rheumatism
452 ☐ Rheumatoid Arthritis
453 ☐ Joint stiffness in the morning
454 ☐ Swollen joints
455 ☐ Leg pain at rest
456 ☐ Spinal curvature
457 ☐ Low back pain
458 ☐ Neck pain
459 ☐ Pain between the shoulders
460 ☐ Shoulder/arm pain
461 ☐ Numbness/tingling in the body
462 ☐ Sleep walks
463 ☐ Stutters or stammers
464 ☐ Nerve pain

Behavior Patterns

150 ☐ Afraid to eat anywhere except home
151 ☐ Always needs someone to advise
152 ☐ Cries often
153 ☐ Difficulty concentrating
154 ☐ Difficulty falling asleep
155 ☐ Difficulty staying asleep
156 ☐ Easily angered
157 ☐ Feelings are easily hurt
158 ☐ Frequently becomes scared for no reason
159 ☐ Frequently miserable or blue
160 ☐ Has to be on guard even with friends
161 ☐ Often annoyed by people
162 ☐ Recurrent bad dreams
163 ☐ Sometimes wishes to be dead or away from it all
164 ☐ Upset by criticism
165 ☐ Poor memory
166 ☐ Scared to be alone
167 ☐ Strange people or places cause fear
168 ☐ Under considerable emotional stress
169 ☐ Unhappy when other are happy
170 ☐ Brain fog

Urinary

555 ☐ Urinates more than 2 times per night
556 ☐ Bed wetting
557 ☐ Blood in the urine
558 ☐ Difficulty starting urination
559 ☐ Painful urination
560 ☐ Frequent urination
561 ☐ Troubled by urgent urination
562 ☐ Incontinence when sneezing or laughing
563 ☐ Loses bladder control
564 ☐ Frequent bladder infections
565 ☐ Frequent kidney infections
566 ☐ Kidney stones

Men Only

585 ☐ Difficulty completing intercourse
586 ☐ Difficulty getting or keeping an erection
587 ☐ Discharge from the urethra
588 ☐ Had a vasectomy
589 ☐ Had difficulty fathering children
590 ☐ Lumps in the testicles
591 ☐ Painful genitals
592 ☐ Prostate troubles
593 ☐ Sores on external genitalia
594 ☐ Herpes
595 ☐ Sexual diseases

Women Only

610 ☐ Heavy hair growth on face or body
611 ☐ Cycles are every 27-29 days
612 ☐ Abnormal cycle >29 days and/or <26 days
613 ☐ PMS
614 ☐ Menstrual cramps
615 ☐ Painful periods
616 ☐ Acne worse at menstruation
617 ☐ Excessive menstrual flow
618 ☐ Retains fluid during periods
619 ☐ Pre-menstrual depression
620 ☐ Currently taking birth control medication
621 ☐ Has taken birth control medication more than 1 year
622 ☐ Has taken birth control medication within the last year
623 ☐ Has had miscarriage
624 ☐ Hot flashes
625 ☐ Takes hormone replacement medication
627 ☐ Diminished sexual desire
628 ☐ Painful intercourse
629 ☐ Poor or infrequent orgasm
630 ☐ Lumps in the breasts
631 ☐ Tender breasts
633 ☐ Vaginal discharge
634 ☐ Bloody spotting discharge
635 ☐ Yeast infections
636 ☐ Sores on external genitalia
637 ☐ Herpes
638 ☐ Sexual diseases
639 ☐ Endometriosis
640 ☐ Breast reduction
641 ☐ Breast augmentation
642 ☐ Abortion
643 ☐ D&C
644 ☐ Tubal pregnancy
645 ☐ Uterine fibroids
646 ☐ Ovarian fibroids
647 ☐ Breast fibroids
648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are currently taking on a daily basis.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

☐ Dairy	☐ Gluten	☐ Ragweed	☐ Sulfa drugs
☐ Eggs	☐ Mold	☐ Shellfish	☐ Tree nuts
☐ Garlic	☐ Peanut	☐ Soy	☐ Wheat

☐ Other _____

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

VITAMIN	***BRAND***	***DOSAGE***