

Hormone Questionnaire

Vitality Chiropractic
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Patient Name _____ Birth Date _____
 Address _____ City/State _____ Zip _____
 Social Security Number _____ E-Mail _____
 Home # _____ Cell # _____

Do you have or have you been diagnosed with any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Vaginal Yeast Infections (Candida) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Uterine Polyps | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Vaginal Dysplasia | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Adrenal Fatigue |
| <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Recurrent Bladder Infections |
| <input type="checkbox"/> Cervical Dysplasia | <input type="checkbox"/> Human Papilloma Virus |
| <input type="checkbox"/> Estrogen Dominance | <input type="checkbox"/> Osteopenia or Osteoporosis |
| <input type="checkbox"/> Intrauterine Endometriosis | <input type="checkbox"/> An Autoimmune Disorder |
| <input type="checkbox"/> Infertility | Which one? _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Gall Bladder Problems |
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Insulin Resistance | What Type? _____ |
| <input type="checkbox"/> Anemia | |

◆Hormones are the body's biochemical messenger system. Tiny amounts of hormones are released directly into the bloodstream and exert profound effects on body processes.

◆Hormones are a main part of the body's control system. They are involved in coordinating and integrating the body, as well as mind and emotions.

Place a check next to the symptoms that currently apply to you.

- | | | |
|--|---|--|
| <input type="checkbox"/> Nervous Tension | <input type="checkbox"/> Insulin Resistance | <input type="checkbox"/> Reduced Pain Threshold |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Muscle/Joint Pain |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heavy Bleeding |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Cold Hands / Feet | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Feel out of Control | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Feeling of Hopelessness | <input type="checkbox"/> Candida | <input type="checkbox"/> Change in Sexual Interest |
| <input type="checkbox"/> Short Fuse | <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Decreased |
| <input type="checkbox"/> Severe Temper | <input type="checkbox"/> Lumps | <input type="checkbox"/> Increased |
| <input type="checkbox"/> Rage | <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Avoidance of Social Situations |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abdominal Bloating | <input type="checkbox"/> Decreased Self-Esteem |
| <input type="checkbox"/> Over Sensitive | <input type="checkbox"/> Belching | <input type="checkbox"/> Increased Interpersonal Conflicts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Gas | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Dry Mucous Membranes |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Vaginal Dryness |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Urinary Frequency |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Excess Facial Hair | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Acne | <input type="checkbox"/> Stretch Marks |
| <input type="checkbox"/> Sweet Cravings | <input type="checkbox"/> Swelling or Edema | <input type="checkbox"/> Others: |
| <input type="checkbox"/> Carbohydrate Cravings | <input type="checkbox"/> Lower Body | _____ |
| <input type="checkbox"/> Chocolate Cravings | <input type="checkbox"/> Hands | _____ |
| <input type="checkbox"/> Binge Eating | <input type="checkbox"/> Eyelids | _____ |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Constipation | _____ |
| | <input type="checkbox"/> Diarrhea | _____ |
| | <input type="checkbox"/> Difficulty Sleeping | _____ |
| | <input type="checkbox"/> Insomnia | _____ |
| | <input type="checkbox"/> Sleeping More Than Usual | _____ |

(Please Turn Over)

Additional Questions:

How many days before your menstrual cycle do you experience PMS symptoms? _____

How long have you had these problems? _____

Are there other times of the month that you regularly experience any of these symptoms? _____

At what age did you begin menstruating? _____ First day of last cycle if still menstruating? _____

Are you still menstruating, if not when was your last full cycle? _____

Age cycles became irregular, painful, heavy or diminished? _____

Do you have bleeding or spotting between cycles? _____

Has your PMS been increasing in severity? **Yes / No** Since when? _____

Is there anything you have found that helps alleviate some of the symptoms? _____

Is there anything you notice that worsens the symptoms? _____

Do you use or have you used oral or injected contraceptives? If yes, when, how long, and what was used? _____

Have you had any of the following exams? (**Mammogram, Bone Density, Pap Smear, Thermography, Blood Tests, Colonoscopy, Biopsies, Physical Exam Blood Pressure or Cholesterol**) If yes, please list dates and results: _____

Do you have children? If yes, how many? _____ Any miscarriages? _____

Have you had your ovaries removed or had a hysterectomy? If yes, when and why? _____

Have you had any surgical procedures done on your thyroid gland? If yes, when and what was done? _____

Are you taking or have taken any synthetic hormones? If yes, which hormones, the dosage, and how are you taking them? _____

List any medications and/or over the counter medications and how often you take them. _____

List current vitamin, herbs or supplements you are taking. _____

Have you seen any medical doctors concerning these issues? If yes, who and what was the outcome? _____

List amount per week/day of any alcohol, tobacco, caffeine (sodas, chocolate, teas and/or coffee). _____

In general, are you getting enough sleep at night? _____ Hours per night? _____ Do you wake tired? _____

If you *are* having sleeping difficulties, how long? _____ Would you consider yourself a light sleeper? _____

Do you take anything to induce sleep? If yes, what and how long? _____

What is your current body weight and height? _____ What weight do you feel best at? _____

Have you been on diets in the past to lose or gain weight? _____

How do you feel presently about your body? _____

List your regular exercise program _____

What are your main concerns and outcome goals for consulting our office? _____