Back In Action Chiropractic
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Female Hormone Questionnaire (March 2011)

Name: **Age:** **Weight:**

Medications currently taken:

Natural supplements or remedies currently taken:

General hormone questions:

1. At what age did you begin menstruating (onset of menarche)?
    a. Number of days in cycle?
    b. How many days bleeding?
2. Have you ever been pregnant?
    a. How many times?
    b. Number of children and ages:
    c. Have you ever had any miscarriages or ectopic pregnancies?
    d. If so, when?
3. Have you used the following contraceptives:
    a. Oral
    b. Injected
    c. Patch

    When and for how long?
    For what reason?
4. Do you have any discomfort, PMS, or other symptoms around the time of your period?

    (If you know around what time, please include the day number in the menses cycle.)

5. Bleeding problems
    a. Heavy bleeding (saturated tampons or pads more than 4x per day)?
    (If yes, for how many days?)
    b. Spotting?
    (If yes, for how many days?)
    c. Clotting?
    d. Cramping?
    (If yes, when in the cycle?)
    e. Other symptoms associated with bleeding?
6. List GYN procedures or surgeries. (Ovaries, hysterectomy, breast, other). Include dates and reasons.

Dr. Back In Action Chiropractic

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Please indicate whether the following symptoms apply to you

Symptom			
Mood swings:	Mild	Moderate	Severe
Irritability:	Mild	Moderate	Severe
Anxiety:	Mild	Moderate	Severe
Short Fuse:	Severe temper	Rage	Aggression
Overly sensitive	Mild	Moderate	Severe
No Self Care Routine	Mild	Moderate	Severe
Depression	Mild	Moderate	Severe
Low Self-esteem	Mild	Moderate	Severe
Sadness	Mild	Moderate	Severe
Crying	Mild	Moderate	Severe
Bloating	Mild	Moderate	Severe
Water retention	Mild	Moderate	Severe
Memory difficulties	Mild	Moderate	Severe
Foggy thinking	Mild	Moderate	Severe
No concentration	Mild	Moderate	Severe
Cravings: eg. Sweets	Mild	Moderate	Severe
Candida (Yeast Infections)	Mild	Moderate	Severe
Hypoglycemia	Mild	Moderate	Severe
Hyperglycemia (Diabetes)			
Weight Gain			
Overweight			
Weight Loss			
Fatigue			
Cold hands and feet			
Change in bowel habits			
Constipation (1x/day or less)			
Diarrhea			
Muscle/joint aches and pains			
Back ache			
Headaches or migraines?	When and how often?	Specific times during your cycle?	
Nausea or vomiting			
Acne			
Oily skin			
Excessive facial hair			
Excessive body hair			
Change in libido:	Increased	Decreased	
Difficulty sleeping			
Insomnia			
Hot flashes			
Night sweats			
Dry eyes			
Vaginal dryness			
Painful intercourse			
Urinary frequency			
Urinary incontinence			

Any other symptoms related to your cycle or concerns not covered in this questionnaire?

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