HOLISTIC
VITALITY CENTER℠

Your Healing Is Our Mission - Your Comfort Is Our Goal

Confidential Patient Information

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: **(Home)** _____ **(Work)** _____ **(Mobile)** _____

Email: _____

Age: _____ **Birth Day:** _____ **Social Security No:** _____

Sex: **M / F** **Marital Status:** Single / Married/ Divorced / Widowed

Occupation: _____ **Employer:** _____

Number of hours worked per week: _____

Spouse's Name: _____ **Phone number:** _____

Number of Children: _____

How did you hear about us: _____

Emergency Contact Information

Emergency Contact: _____

Contact Phone: _____

Relationship to Emergency Contact: _____

Insurance Information

Insurance Company: _____

Policy: _____

Address: _____

Group: _____ **Phone Number:** _____

Primary Care Physician: _____

Primary Insurance Holder

Name: _____

Insured's SSN: _____

Relationship to Insured: _____

Date Of Birth: _____ **Phone Number:** _____

Experience with Holistic Medicine

Have you ever been to a Holistic Practitioner? ☐ Yes ☐ No

Please check if you have experienced:

☐	**Acupuncture**	☐	**Aromatherapy**
☐	**Chiropractic Medicine**	☐	**Diet and Lifestyle Modification**
☐	**Functional Medicine**	☐	**Medical Massage**
☐	**Mind-Body Medicine (Biofeedback)**	☐	**Naturopathy**

Reason for those Visit? _____

Was the care helpful? _____

Reason for Visit

Purpose of Appointment: _____

_____

When did the conditions begin? _____

Do you remember what caused it? _____

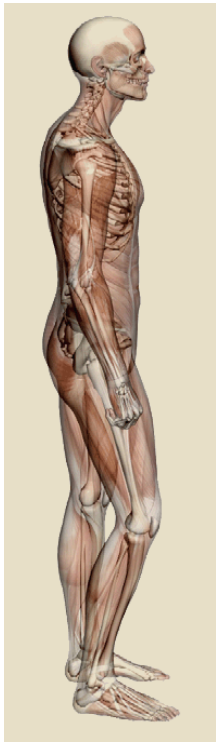
If you have pain, please rate your pain on a scale of 1-10 (10 - severe and 1 - no pain): _____

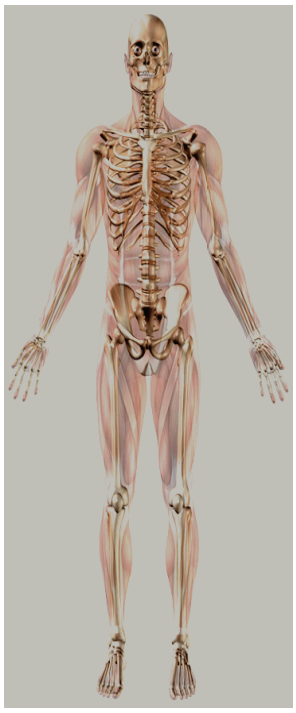
Other Doctors Seen For This Condition: _____

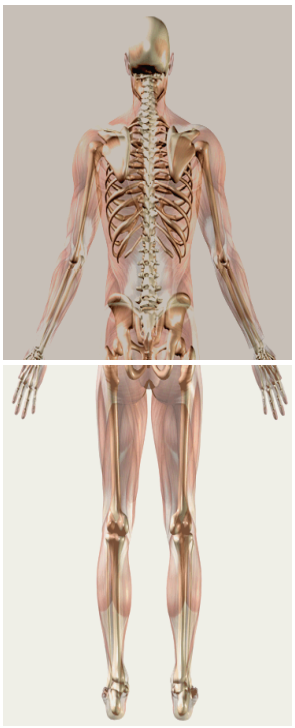
Have you ever been treated for any other condition in the past year? ☐ Yes ☐ No

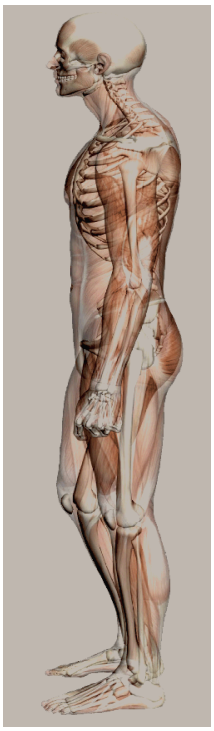
If so, describe: _____

_____









Please mark an "X" to indicate areas where you feel pain, swelling, or discomfort.
Describe what you feel or observe in your own words. Write anywhere in this area.

Health Intake

Height: _____ **Weight:** _____

Known Allergies _____

Blood Type _____

Medications/Drugs taking (State reason for each medication):

_____

_____

Herbs or Supplements: _____

_____

Do you have allergies to any medication or botanicals/herbs: ☐ Yes ☐ No

If yes, list medications or botanicals/herbs and reaction: _____

_____

List all Surgeries, Hospitalizations and Serious Illnesses (List year):

_____

_____

Diagnostic Imaging (CT scan, MRI, MRA, Contrast Studies, X-Rays including dental and Spinal)

Age	Body Area	Type (Normal

Lifestyle Habits

Do you smoke: ☐ Yes ☐ No **What?** _____ **How Many/day:** _____

Tobacco Products: ☐ Yes ☐ No **What?** _____ **How Many/Day:** _____

Substance Abuse? ☐ Yes ☐ No **What?** _____ **How Many/Day:** _____

Drink Coffee? ☐ Yes ☐ No **Cups/Day** _____

Drink Tea? ☐ Yes ☐ No **Cups/Day** _____

Colas/Soft Drinks? ☐ Yes ☐ No **No./Day** _____

Alcohol Drinks? ☐ Yes ☐ No **Avg./Week** _____

Water Intake? ☐ Yes ☐ No **No. of Glasses per day:** _____

Do you eat in fast food restaurants? ☐ Yes ☐ No **How many times/week?** _____

Are you Dieting? ☐ Yes ☐ No **Reasons** _____

Bowel Movement Frequency: _____ **Difficulty?** ☐ Yes ☐ No

Do you sleep well? ☐ Yes ☐ No **If No, Describe:** _____

_____

Do you have Sufficient energy for normal activities? ☐ Yes ☐ No

If No, Describe: _____

_____

Do you have corrective lenses: ☐ Yes ☐ No **Has your Vision Changed recently?** ☐ Yes ☐ No

Do you wear Heel Lifts or Foot Supports: ☐ Yes ☐ No **Explain:** _____

_____

Place a "✓" to indicate if you or your family currently have or have had any of the following:

	Self	Family		Self	Family
AIDS/HIV	☐	☐	Herniated Disc	☐	☐
Alcoholism	☐	☐	High Blood Pressure	☐	☐
Allergy	☐	☐	High Cholesterol	☐	☐
Anemia	☐	☐	Heart Disease	☐	☐
Anorexia/Bulemia	☐	☐	Kidney Disease	☐	☐
Anxiety Attacks	☐	☐	Liver Disease	☐	☐
Asthma	☐	☐	Multiple Sclerosis	☐	☐
Auto Immune Disease	☐	☐	Osteoporosis	☐	☐
Bleeding Disorder	☐	☐	PMS	☐	☐
Breast Lumps	☐	☐	Prostate Problems (men)	☐	☐
Cancer	☐	☐	Psychiatric Care	☐	☐
Celiac Disease	☐	☐	Rheumatoid Arthritis	☐	☐
Chronic Fatigue	☐	☐	Sleep Problems	☐	☐
Crohn's Disease	☐	☐	Stroke	☐	☐
Depression	☐	☐	Thyroid Problems	☐	☐
Diabetes	☐	☐	Tumor/Growth (non-cancer)	☐	☐
Digestion Problems	☐	☐	Ulcers	☐	☐
Fibromyalgia	☐	☐	Vaginal Infections	☐	☐
Gout	☐	☐	Others:		

Name _____ **Date** _____

DIRECTIONS:

This questionnaire asks you to assess how you have been feeling **during the last four (4) months.** This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, and level of physical activity. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

(1) **No/Rarely** – You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less).
(2) **Occasionally** – Symptom comes and goes and is linked in your mind to stress, diet, fatigue and/or some identifiable trigger.
(3) **Often** – Symptom occurs two to three times per week and/or with a frequency that bothers you enough that you would like to do something about it.
(4) **Frequently** – Symptom occurs four or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis.

Some questions may require a simple YES or NO response.

PART I: SECTION A

1.	Indigestion, food repeats on you after you eat	1 2 3 4
2.	Excessive burping, belching and/or bloating following meals	1 2 3 4
3.	Stomach spasms & cramping during or after eating	1 2 3 4
4.	A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	1 2 3 4
5.	Bad taste in your mouth	1 2 3 4
6.	Small amounts of food fill you up immediately	1 2 3 4
7.	Skip meals or eat erratically because you have no appetite	1 2 3 4

SECTION B

1.	Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	1 2 3 4
2.	Feel hungry an hour or two after eating a good-sized meal	1 2 3 4
3.	Stomach pain, burning and/or aching over a period of one to four hours after eating	1 2 3 4
4.	Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	1 2 3 4
5.	Burning sensation in the lower part of your chest, especially when lying down or bending forward	1 2 3 4
6.	Digestive problems that subside with rest or relaxation	NO YES
7.	Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes stomach burn/ache	1 2 3 4
8.	Feel a sense of nausea when you eat	1 2 3 4
9.	Difficulty or pain when swallowing food or beverage	1 2 3 4

SECTION C

1.	When massaging under your rib cage on your *left* side, there is pain, tenderness or soreness	1 2 3 4
2.	Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	1 2 3 4
3.	Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	1 2 3 4
4.	Specific foods/beverages aggravate indigestion	1 2 3 4
5.	The consistency or form of your stools changes (e.g., from narrow to loose) within the course of a day	1 2 3 4
6.	Stool odor is embarrassing	1 2 3 4
7.	Undigested food in your stool	1 2 3 4
8.	Three or more large bowel movements daily	1 2 3 4
9.	Diarrhea (frequent loose, watery stool	1 2 3 4
10.	Bowel movement shortly after eating (1 hour)	1 2 3 4

SECTION D

1.	Discomfort pain or cramps in your lower abdominal area	1 2 3 4
2.	Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	1 2 3 4
3.	Generally constipated or straining during movements	1 2 3 4
4.	Stool is small, hard and dry	1 2 3 4
5.	Pass mucus in your stool	1 2 3 4
6.	Alternate between constipation and diarrhea	1 2 3 4
7.	Rectal pain, itching or cramping	1 2 3 4
8.	No urge to have a bowel movement	NO YES
9.	An almost continual need to have a bowel movement	NO YES

PART II

1.	When massaging under your rib cage on your *right* side, there is pain, tenderness or soreness	1 2 3 4
2.	Abdominal pain worsens with deep breath	1 2 3 4
3.	Pain at night that may move to your back or right shoulder	1 2 3 4
4.	Bitter fluid repeats after eating	1 2 3 4
5.	Feel abdominal discomfort or nausea when eating rich, fatty or fried foods	1 2 3 4
6.	Throbbing temples and/or dull pain in forehead	1 2 3 4
7.	Unexplained itchy skin that's worse at night	1 2 3 4
8.	Stool color alternates from clay colored to normal brown	1 2 3 4
9.	General feeling of poor health	1 2 3 4
10.	Aching muscles not due to exercise	1 2 3 4
11.	Retain fluid and feel swollen around abdomen	1 2 3 4
12.	Reddened skin, especially palms	1 2 3 4
13.	Very strong body odor	1 2 3 4
14.	Are you embarrassed by your breath?	1 2 3 4
15.	Bruise easily	NO YES
16.	Yellowish cast to eyes	NO YES

PART III: SECTION A

1.	Feel cold or chilled-hands feet or all over for no reason	1 2 3 4
2.	Your eyelids look swollen	1 2 3 4
3.	Muscles are weak, cramp and/or tremble	1 2 3 4
4.	Are you forgetful?	1 2 3 4
5.	Do you feel like your heart beats slowly?	1 2 3 4
6.	Reaction time seems slowed down	1 2 3 4
7.	In general, are you disinterested in sex due to low desire?	1 2 3 4
8.	Feel slow-moving, sluggish	1 2 3 4
9.	Constipation	1 2 3 4
10.	Dryness, discoloration of skin and/or hair	NO YES
11.	Have you noticed recently that your voice is deepening?	NO YES
12.	Thick brittle nails	NO YES
13.	Weight gain for no apparent reason	NO YES
14.	Outer third of your eyebrow is thinning or disappearing	NO YES
15.	Swelling of the front of the neck	NO YES

SECTION B

1.	Lingering mild fatigue after exertion or stress	1 2 3 4
2.	Do you find that you get tired and exhaust easily?	1 2 3 4
3.	Craving for salty foods	1 2 3 4
4.	Sensitive to minor changes in weather and surroundings	1 2 3 4
5.	Dizzy when rising or standing up from a kneeling position	1 2 3 4
6.	Dark bluish or black circles under eyes	1 2 3 4
7.	Have bouts of nausea with or without vomiting	1 2 3 4
8.	Catch colds or infections easily	NO YES
9.	Wounds heal slowly	NO YES
10.	Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	1 2 3 4
11.	Feel puffy and swollen all over your body	1 2 3 4
12.	Skin is gradually tanning without exposure to sun	NO YES

PART IV: SECTION A

When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?

1.	A sense of weakness	1 2 3 4
2.	A sudden sense of anxiety when you get hungry	1 2 3 4
3.	Tingling sensation in your hands	1 2 3 4
4.	A sensation of your heart beating too quickly or forcefully	1 2 3 4
5.	Shaky, jittery, hands trembling	1 2 3 4
6.	Sudden profuse sweating and/or your skin feels clammy	1 2 3 4
7.	Nightmares possible associated with going to bed with an empty stomach	1 2 3 4
8.	Wake up at night feeling restless	1 2 3 4
9.	Agitation, easily upset, nervous	1 2 3 4
10.	Poor memory, forgetful	1 2 3 4
11.	Confused or disoriented	1 2 3 4
12.	Dizzy, faint	1 2 3 4
13.	Cold or numb	1 2 3 4
14.	Mild headaches or head pounding	1 2 3 4
15.	Blurred vision or double vision	1 2 3 4
16.	Feel clumsy and uncoordinated	1 2 3 4

SECTION B

1.	Frequent urination during the day and night	1 2 3 4
2.	Unusual thirst-feeling like you can't drink enough	1 2 3 4
3.	Unusual hunger-eating all of the time	1 2 3 4
4.	Vision blurs	1 2 3 4
5.	Feel itchy all over	1 2 3 4
6.	Tingling or numbness in your feet	1 2 3 4
7.	Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	1 2 3 4
8.	Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing	NO YES
9.	Sores heal slowly	NO YES
10.	Loss of hair on your legs	NO YES

PART V: SECTION A

1.	Family, friends, work, hobbies or activities you hold dear are no longer of interest	1 2 3 4
2.	Do you cry?	1 2 3 4
3.	Does life look entirely hopeless?	1 2 3 4
4.	Would you describe yourself as feeling miserable and sad, unhappy or blue?	1 2 3 4
5.	Do you find it hard to make the best of difficult situations?	1 2 3 4
6.	Sleep problems-too much or too little sleep	1 2 3 4
7.	Changes in your appetite and weight	NO YES
8.	Lately you've noticed an inability to think clearly or concentrate	NO YES
9.	Difficulty making decisions and/or clarifying and achieving your goals	NO YES

SECTION B

1.	Does worrying get you down?	1 2 3 4
2.	Does every little thing get on your nerves and wear you out?	1 2 3 4
3.	Would you consider yourself a nervous person?	1 2 3 4
4.	Do you feel easily agitated?	1 2 3 4
5.	Do you shake and tremble?	1 2 3 4
6.	Are you keyed up and jittery?	1 2 3 4
7.	Do you tremble and feel weak when someone shouts at you?	1 2 3 4
8.	Do you become scared at sudden movements or noises at night?	1 2 3 4
9.	Do you find yourself sighing a lot?	1 2 3 4
10.	Are you awakened out of your sleep by frightening dreams?	1 2 3 4
11.	Do frightening thoughts keep coming back in your mind	1 2 3 4
12.	Do you become suddenly scared for no reason?	1 2 3 4
13.	Do you break out in a cold sweat?	1 2 3 4
14.	"Butterflies in your stomach", nausea and/or diarrhea	1 2 3 4

SECTION C

1.	Do you feel pent up and ready to explode?	1 2 3 4
2.	Are you prone to noisy and emotional outbursts?	1 2 3 4
3.	Do you do things on impulse?	1 2 3 4
4.	Are you easily upset or irritated?	1 2 3 4
5.	Do you go to pieces if you don't control yourself?	1 2 3 4
6.	Do little annoyances get on your nerves and make you angry?	1 2 3 4
7.	Does it make you angry to have anyone tell you what to do?	1 2 3 4
8.	Do you flare up in anger if you can't have what you want right away?	1 2 3 4

PART VI: SECTION A

1.	Eyes water or tear	1 2 3 4
2.	Mucus discharge from the eyes	1 2 3 4
3.	Ears ache, itch, feel congested or sore	1 2 3 4
4.	Discharge from ears	1 2 3 4
5.	Is your nose continually congested?	1 2 3 4
6.	Are you prone to loud snoring?	NO YES
7.	Does your nose run?	1 2 3 4
8.	Nosebleeds	NO YES
9.	Hoarse voice	1 2 3 4
10.	Do you have to clear your throat?	1 2 3 4
11.	Do you feel a choking lump in your throat?	1 2 3 4
12.	Do you suffer from severe colds?	NO YES
13.	Do frequent colds keep you miserable all winter?	NO YES
14.	Flu symptoms last longer than 5 days?	NO YES
15.	Do infections settle in your lungs?	NO YES
16.	Chest discomfort or pain?	1 2 3 4

1	Do you experience sudden breathing difficulties?	1 2 3 4
18.	Do you struggle with shortness of breath?	1 2 3 4
19.	Difficulty exhaling (breathing out)	1 2 3 4
20.	Breathlessness followed by coughing during exertion, no matter how slight	1 2 3 4
21.	Inability to breath comfortably while lying down	1 2 3 4
22.	Do you cough up lots of phlegm?	1 2 3 4
23.	Can you hear noisy rattling sounds when breathing in and out?	1 2 3 4
24.	Are you troubled with coughing?	1 2 3 4
25.	Do you wheeze?	1 2 3 4
26.	Do you have severe soaking sweats at night?	1 2 3 4
27.	Do your lips and/or nails have a bluish hue?	1 2 3 4
28.	Are you sleepy during the day?	1 2 3 4
29.	Do you have difficulty concentrating?	1 2 3 4
30.	Eyes, ears, nose throat and lung symptoms seem associated with specific foods like dairy or wheat products	NO YES
31.	Eyes, ears, nose, throat, and lung symptoms are associated with seasonal changes	NO YES

PART VII: SECTION A

1.	Bones throughout your entire body ache, feel tender or sore	1 2 3 4
2.	Localized bone pain	1 2 3 4
3.	Hands, feet or throat get tight, spasm or feel numb	1 2 3 4
4.	Difficulty sitting straight	1 2 3 4
5.	Upper back pain	1 2 3 4
6.	Lower back pain	1 2 3 4
7.	Pain when sitting down or walking	1 2 3 4
8.	Find yourself limping or favoring one leg	1 2 3 4
9.	Shins hurt during or after exercise	1 2 3 4

SECTION B

1.	Are you stiff in the morning when you wake up?	1 2 3 4
2.	Difficulty bending down and picking up clothing or anything from the floor	1 2 3 4
3.	Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet ankles, or knees	1 2 3 4
4.	Joints hurt when moving or when carrying weight	1 2 3 4
5.	A routine exercise program, like daily walking, causes your knees to swell or hurt	1 2 3 4
6.	Difficulty opening jars that were previously easy to open	1 2 3 4
7.	Discomfort, numbness, prickling or tingling sensations, or pain in neck, shoulder or arm	1 2 3 4
8.	Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	1 2 3 4
9.	Difficulty chewing food or opening mouth	1 2 3 4
10.	Difficulty standing up from a sitting position	1 2 3 4
11.	Shooting, aching, tingling pain down the back of the leg	1 2 3 4
12.	Difficulty reaching above head to lift something	NO YES
13.	Injure, strain or sprain easily?	NO YES

SECTION C

1.	Muscles stiff, sore, tense and/or achy	1 2 3 4
2.	Burning, throbbing, shooting or stabbing muscle pain	1 2 3 4
3.	Muscle cramps or spasms (involuntary or after exertion/exercise)	1 2 3 4
4.	Is muscle pain or stiffness greater in the morning than other times of the day?	1 2 3 4
5.	Specific points on body feel sore when pressed	1 2 3 4
6.	Feel unrefreshed upon awakening	1 2 3 4
7.	Headaches	1 2 3 4
8.	Pain at the sides of your head or in your face especially when awakening	1 2 3 4
9.	Your jaw clicks or pops	1 2 3 4
10.	Muscle twitch or temor-eyelids, thumb, calf muscle	1 2 3 4
11.	Irresistible urge to move legs	1 2 3 4
12.	Legs move during sleep	1 2 3 4
13.	Unpleasant crawling sensation inside calves	1 2 3 4
14.	Hand and wrist numbness or pain (e.g., interferes with writing or with buttoning or unbuttoning your clothes)	1 2 3 4
15.	Feelings of “pins and needles” in your thumb and first three fingers	1 2 3 4
16.	Pain in forearm and sometimes in shoulder	1 2 3 4

PART VIII: SECTION A

1.	Head feels heavy	1 2 3 4
2.	Dizziness	1 2 3 4
3.	Difficulty bending over, standing up from sitting, rolling over in bed and/or turning head from side to side	1 2 3 4
4.	Your hands tremble, ever so slightly, for no apparent reason	1 2 3 4

5.	You feel like you're wearing heavy weights on your feet when walking	1 2 3 4
6.	Bump into things, trip, stumble and feel clumsy	1 2 3 4
7.	Difficulty breathing	1 2 3 4
8.	Difficulty swallowing	1 2 3 4
9.	People tell you to speak up because they have trouble hearing you	1 2 3 4
10.	Speaking and forming words does not feel automatic	1 2 3 4
11.	Need 10-12 hours of sleep to feel rested	1 2 3 4
12.	Lack of strength (your grip is weak, holding your head or picking your arms up takes effort)	1 2 3 4
13.	Hands get tired when you write and your handwriting is less legible and smaller than it used to be	NO YES
14.	Muscles in arms and legs seem softer and smaller	NO YES
15.	Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be?	NO YES
16.	Do you find yourself moving slower than you used to	NO YES

SECTION B

1.	Difficulty absorbing new information	1 2 3 4
2.	Tend to forget things	1 2 3 4
3.	Trouble thinking or concentrating	1 2 3 4
4.	Easily distracted	1 2 3 4
5.	Do you have a tendency to become frustrated quickly?	1 2 3 4
6.	Inability to sit still for any length of time, even at mealtime	1 2 3 4
7.	Finishing tasks is easier said than done	1 2 3 4
8.	Do you have more trouble solving problems or managing your time than usual?	1 2 3 4
9.	Low tolerance for stress and otherwise ordinary problems	1 2 3 4

PART IX: SECTION A

MEN ONLY*************************************

1.	Sensation of not emptying your bladder completely	1 2 3 4
2.	Need to urinate less than 2 hours after you have finished urinating	1 2 3 4
3.	Find yourself needing to stop and start again several times while urinating	1 2 3 4
4.	Find it difficult to postpone urination	1 2 3 4
5.	Have a weak urinary system	1 2 3 4
6.	Need to push or strain to begin urination	1 2 3 4
7.	Dripping after urination	1 2 3 4
8.	Urge to urinate several times a night	1 2 3 4

PART X: ***************** WOMEN ONLY********************************

(Menopausal women skip to Sections E and F)

SECTION A

Do you persistently experience any of these symptoms within three (3) days to two (2) weeks *prior to menstruation?*

1.	Anxious, irritable or restless	NO YES
2.	Numbness, tingling in hands and feet	NO YES
3.	Easy to anger, resentful	NO YES
4.	Aggressive or hostile toward family/friends	NO YES
5.	Abdominal bloating, feeling swollen (e.g., feet)	NO YES
6.	Temporary weight gain	NO YES
7.	Breast tenderness, swelling	NO YES
8.	Appearance of breast lumps	NO YES
9.	Discharge from nipples	NO YES
10.	Nausea and/or vomiting	NO YES
11.	Diarrhea or constipation	NO YES
12.	Aches and pains (back, joints, etc.)	NO YES
13.	Craving for sweets	NO YES
14.	Increased appetite or binge eating	NO YES
15.	Headaches	NO YES
16	Being easily overwhelmed, shaky or clumsy	NO YES
17.	Heart pounding	NO YES
18.	Dizziness or fainting	NO YES
19.	Confused and forgetful to the point that work suffers	NO YES
20.	Overwhelmed with feeling of sadness and worthlessness	NO YES
21.	Difficulty sleeping or falling asleep	NO YES
22.	Engaging in self-destructive behavior	NO YES

SECTION B

Do you experience any of these symptoms during your period?

1.	Cramping in lower abdomen or pelvic area	NO YES
2.	Lower abdominal pain is sharp and/or dull or intermittent	NO YES
3.	Bloating and sense of abdominal fullness	NO YES
4.	Diarrhea or constipation	NO YES
5.	Nausea and/or vomiting	NO YES

6.	Low back and/or legs ache	NO YES
7.	Headaches	NO YES
8.	Unusual fatigue (take naps) resulting in missed work	NO YES
9.	Painful and/or swollen breasts	NO YES
10.	Scanty blood flow	NO YES

SECTION C

1.	Painful or difficult sexual intercourse	1 2 3 4
2.	Low abdominal, back and vaginal pain throughout the month	1 2 3 4
3.	Pelvic pressure or pain while sitting down or standing up, relieved by lying down	1 2 3 4
4.	Vaginal bleeding other than during your period	1 2 3 4
5.	Painful bowel movements	1 2 3 4
6.	Difficult (straining) urination	1 2 3 4
7.	Abnormal vaginal discharge	1 2 3 4
8.	Offensive vaginal discharge	1 2 3 4
9.	Vaginal itching or burning with or without intercourse	1 2 3 4
10.	Pain during periods is getting progressively worse	NO YES
11.	Profuse or prolonged menstrual bleeding	NO YES
12.	Unable to get pregnant	NO YES

SECTION D

1.	Absence of period for six months or longer	NO YES
2.	Periods occur irregularly (e.g., 3-6 times a year)	NO YES
3.	Profuse heavy bleeding during periods	1 2 3 4
4.	Menstrual blood contains clots and tissue	1 2 3 4
5.	Bleeding between periods can occur anytime	1 2 3 4
6.	Periods occur greater than every 35 days	NO YES
7.	Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	1 2 3 4
8.	Bleeding occurs at ovulation (day 14 of your cycle)	1 2 3 4
9.	Monthly abdominal pain without bleeding	1 2 3 4
10.	Abundant cervical mucus	1 2 3 4
11.	Acne and/or oily skin	1 2 3 4
12.	Overwhelming urges for sexual intercourse	1 2 3 4
13.	Aggressive feelings	1 2 3 4
14.	Increased growth of dark facial and/or body hair	NO YES
15.	Poor sense of smell	NO YES
16.	Voice is becoming deeper	NO YES
17.	Breasts seem to be getting smaller	NO YES
18.	Receding hairline	NO YES

SECTION E

1.	Vaginal discharge	1 2 3 4
2.	Vaginal secretions are watery and thin	1 2 3 4
3.	Vaginal dryness	1 2 3 4
4.	Sexual intercourse is uncomfortable	1 2 3 4
5.	Interest in having sex is low	1 2 3 4
6.	Engorged breasts	1 2 3 4
7.	Breast tenderness, soreness	1 2 3 4
8.	Difficulty with orgasm	1 2 3 4
9.	Vaginal bleeding after sexual intercourse	1 2 3 4
10.	Do you skip periods	NO YES
11.	The length (# days) of your period varies month to month, with the number of days of bleeding getting fewer	NO YES

SECTION F

1.	Sense of well-being fluctuates throughout the day for no apparent reason	1 2 3 4
2.	Sudden hot flashes	1 2 3 4
3.	Spontaneous sweating	1 2 3 4
4.	Chills	1 2 3 4
5.	Cold hands and feet	1 2 3 4
6.	Heart beats rapidly or feels like it is fluttering	1 2 3 4
7.	Numbness, tingling or prickling sensations	1 2 3 4
8.	Dizziness	1 2 3 4
9.	Mental fogginess, forgetful or distracted	1 2 3 4
10.	Inability to concentrate	1 2 3 4
11.	Depression, anxiety, nervousness and/or irritability	1 2 3 4
12.	Difficulty sleeping	1 2 3 4
13.	Conscious of new feelings of anger and frustration	1 2 3 4
14.	Skin, hair, vagina and/or eyes feel dry	1 2 3 4
15.	Stopped menstruating around six months ago, yet still experiencing some vaginal bleeding	NO YES

Release of Information

All information provided herein is true and correct. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information to related health care providers, assignees and/or beneficiaries and other related persons. I have read and understood this release. I understand detailed copy of my HIPAA rights can be provided upon request.

X_____ Date_____

Payment Policy

Payment of all services rendered is due at the time of service to Holistic Vitality Center, PLLC. I have read and understood this policy.

X_____ Date_____

Appointment Cancellation Policy

I understand that 24 hours notice is required when canceling an appointment. I also understand that $30 fee will be charged if I do not cancel 24 hours prior to my appointment.

X_____ Date_____