

Please check box that best describes your period:

- Scant, thin, red
- Heavy, dark, clotted
- Normal red flow

Do you suffer from premenstrual syndrome (PMS)? _____

Do you or is there a history of blood sugar disorders in your family? _____

Do you have any allergies? _____

Do you sleep well? _____

What are your normal sleeping hours? _____ to _____

Do you have any sleeping difficulties? _____

If so please explain _____

- Difficulty falling asleep?
- Wakes up frequently ?

Do you have pain regularly in any location? _____

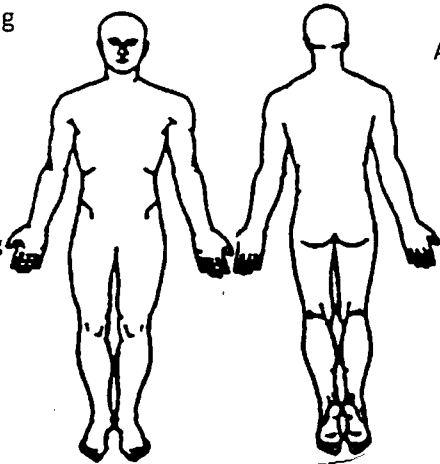
Please mark the areas of discomfort

Please check the box that best describes weather your pain or symptom(s) limit norma activities:

Or pain on the figures

To the right using the symbol that best describes the feeling:

- +++ Sharp/stabbing
- ooo Pins & needles
- vvv Dull or aching
- /// Numbness



Activity	Normal	Somewhat limited	Severely limited
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently under the care of a medical doctor or any other health provider for any condition? _____

Name of condition _____

Name of Doctor/Provider _____

Address of Doctor/Provider _____

Do you get low back pain pre, during or post menstrual? _____

Have you ever had an overnight stay in the hospital or a surgical procedure of any kind? _____

No Yes If yes, please describe each event below:

Event _____ Year _____

Event _____ Year _____

Please check the boxes that best describes your digestion:

- Good Indigestion Constipation Diarrhea Poor Appetite
- Cravings (describe) _____

Do you exercise ? Yes No If yes, please describe activity _____

How many days a week? _____ How many minutes per session _____

- Do you keep your feeling, thoughts and opinions to yourself? _____
- Are you a chronic overthinker? Can't shut your mind down _____
- Enjoy physical contact and emotional intimacy? _____
- Do you put others needs above your own? _____
- Are you expressively hard on yourself? _____
- Do you have a lack of libido? _____
- Do you have diminished recall of recent information or events ? _____
- Do you have diminished acuity of vision or hearing? _____
- Do you have hypersensitive vision and hearing? _____
- Do you have frequent, slow or suppressed urination? _____
- Do you have a loss of pubic or head hair? _____
- Do you have dark brown, purple, or black circles around the eyes? _____
- Do you have tenderness and hardness of ovaries or cervix? _____
- Do you have pain at the temples, sides, back or top of head? _____
- Do you have vertigo and nausea? _____
- Do you have sudden blurring of vision or ringing in the ears? _____
- Do you have split, hardened, or thickened nails? _____
- Do you have premenstrual grouchiness and depression? _____
- Do you have excessive perspiration? _____
- Do you have a sense of being flushed or over heated ? _____
- Do you have a rapid or irregular heartbeat? _____
- Do you have a burning sensation in the mouth, urethra, rectum , or vagina? _____
- Do you have a diminished long term memory? _____
- Do you have obsessive desire for or avoidance of food? _____
- Do you have frequent bloating of the abdomen, especially in the evening? _____
- Do you have swollen, sore, or bleeding gums? _____
- Do you have generalized puffiness or edema? _____
- Do you lack stamina? _____
- Do you have premenstrual lethargy, bloating, and water retention? _____
- Do you have prolapse of the veins in the rectum (hemorrhoids) or legs(varicosities) _____
- Do you have dryness of the nose, throat, skin or hair? _____
- Do you have itching from the dryness? _____
- Do you have enlarged, hard lymph nodes, along the sides of the neck or jaw? _____
- Do you have congestion of the nose, sinuses, or larynx? _____
- Do you have frontal headaches due to dryness or congestion with mucus? _____