Dr. Stephen C. Gangemi
Applied Kinesiologist
Chiropractic Physician

10295 US 15-501 N
Chapel Hill, NC 27517
(984) 234-3313

HEALTH QUESTIONAIRE FOR WOMEN

Personal Information

Full name ____ Name you wish to be called _________________

Street Address ____

City ___________________________ State _______ Zip ___________

Phone: H) ______________________ W) ______________________ E-Mail: ______________________

Date of birth ____/____/____ Gender: F Insurance Company: _________________________

Occupation: __________________________________ Employer: __________________________________

Who were you referred by? __________________________________

Person to contact in case of emergency _________________________________ Phone _________________

Primary Concern

What brings you to my office? ____

____

____

Date of original condition: _____________ Date of most recent occurrence: ________________

Was there an event that created the condition? ____

Have you had this or similar conditions in the past? ____

What makes it better? ____ Worse? ______________________________

Is the condition getting worse? ________________Constant? _______________

Worse at a certain time of day?________________

Is this condition interfering with: Work? _______Sleep? __________ Activity? __________Other? ___________

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being.

____

____

____

Health History

List other current health issues & problems: ____

____

____

List other practitioners seen, treatments, self-care activities, and results:________________________________

____

____

____

List illness you have had not previously mentioned, if any: ____________________________________

____

List all surgeries you have had, with dates and results: ______________________________________

____

____

Have you ever been in an accident or seriously injured? (if so, please describe)__________________________

____

____

Do you have any dental or TMJ problems? Y N (if so, please describe) ____________________________

____

Have you had your wisdom teeth or other teeth removed? Y N *Have you ever had a root canal? Y N

(if yes note which teeth) ____

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking (**please bring actual bottles w/pills in with you to your appointment**):

____

____

____

____

List all medications and other substances (i.e.: foods) to which you are allergic: ___________________________

Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father ___________________________ Mother__________________ Children__________________

Grandparents ______________________ Brothers _________________ Sisters__________________

General

*Describe your use of: Cigarettes/Tobacco _____________Alcohol _____________________ Other drugs_________________

*Describe your present exercise habits including frequency per week, duration, and heart rate: ___________________________

____

____

* How many hours per night do you sleep? ____ * Do you fall right asleep? Y N * Do you wake up feeling refreshed? Y N

* Do you sleep through the night without awaking? Y N * Do you remember your dreams? Y N

* Do you snore? Y N *Do you have night sweats? Y N * Do you have nightmares? Y N

* Do you grind your teeth at night (bruxism)? Y N * Do you have restless legs (RLS)? Y N

*When did you last receive the following (leave blank if it does not apply to you), (please remember to bring copies).

*Cholesterol or other blood tests ____

*Pap smear ___________ *Mammogram________________* Other______________

Pain Questionnaire

(Skip to the next section if you are not currently experiencing pain.)

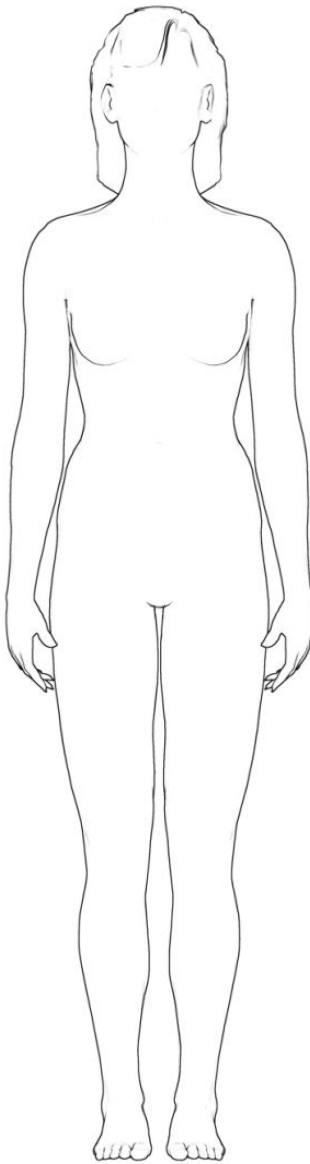
Please place a single vertical line through the scale below at the point that best describes your pain. (0 is no pain, 10 is the worst pain imaginable)

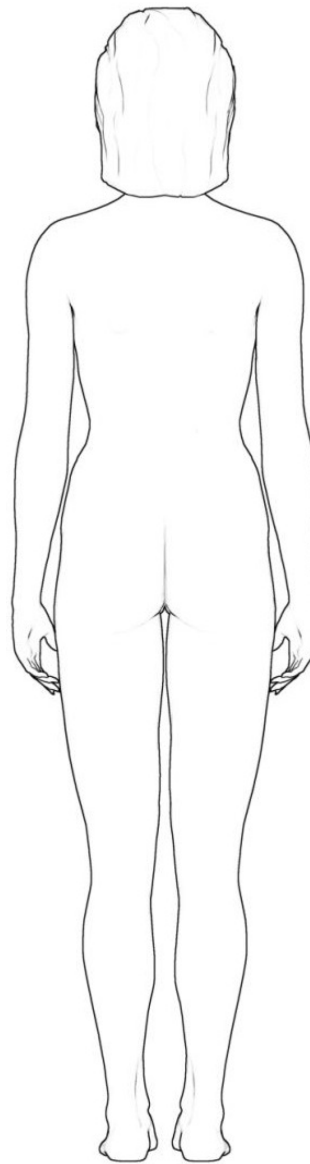
0.........|.........|.........|.........|.........|.........|.........|.........|.........|.........10

Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

A = Ache **B = Burning** **N = Numbness** **O = Other**

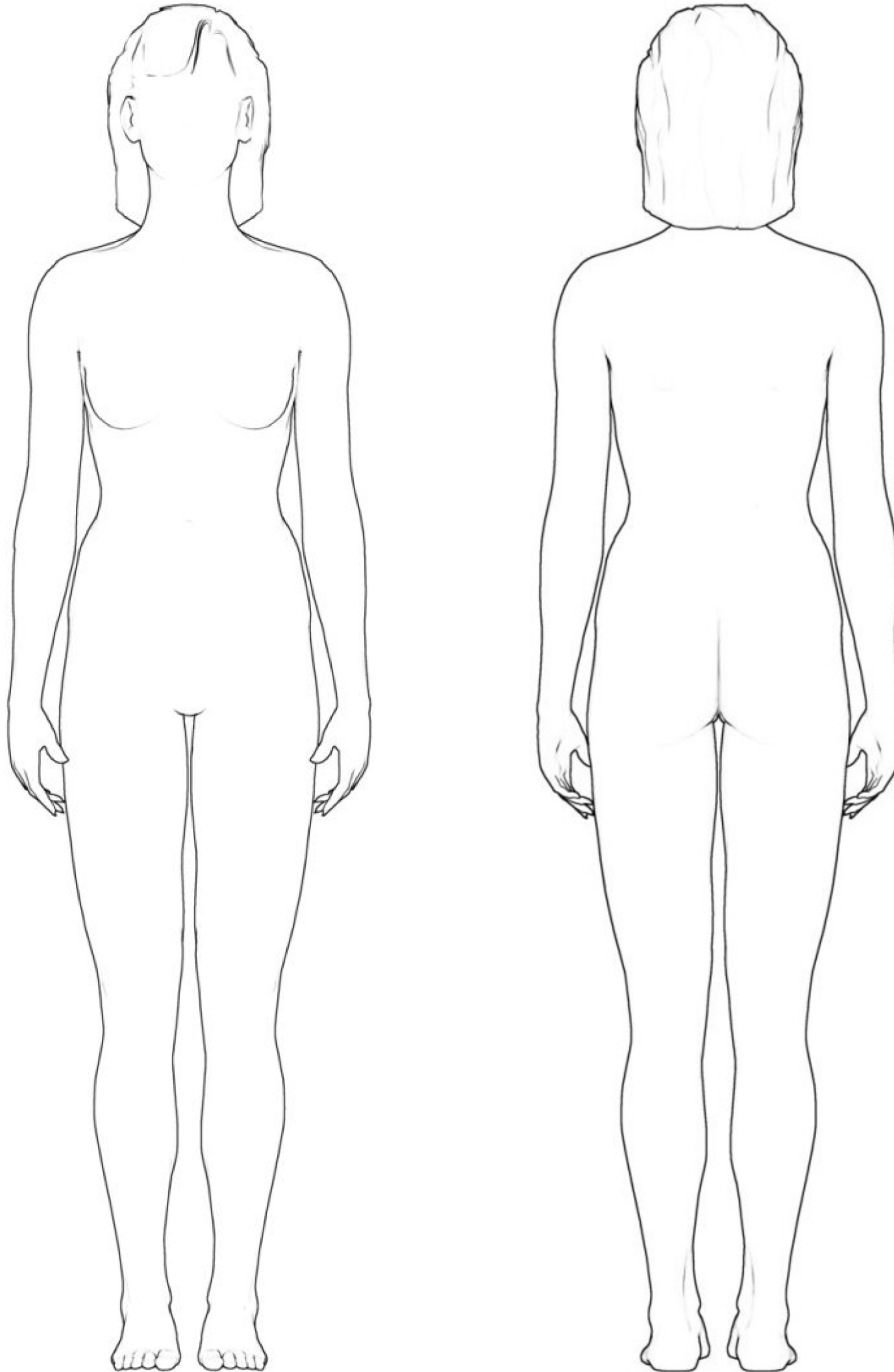
P = Pins & Needles **S = Stabbing** **T = Throbbing**





History of Injury

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



SYMPTOM SURVEY

Circle the symptom if you are currently experiencing it or it is a common occurrence. Underline the symptom if it is now not a problem, but was sometime in the past, (over 3 months ago).

GENERAL

Low energy -fatigue
Weakness
Fever - Chills
Headaches
Lack of sleep
Reduced mental acuity

SKIN

Dry skin
Itching
Varicose veins
Cold or canker sores/fever blisters
Boils
Hives
Rashes
Sores
Change in your skin/nails

EYES

Cataracts/Glaucoma
Eye pain
Double vision
Far or near sightedness
Flashing lights
Spots, specks, or floaters

EARS

Ear discharge/excessive wax
Earaches or infections
Hearing loss
Ringing/tinnitus
Vertigo/dizziness

NOSE/SINUS

Sinus congestion
Frequent colds/infections
Nosebleeds

NECK

Goiter
Lumps
Pain/stiffness
Swollen glands

RESPIRATORY

Asthma
Bronchitis
Cough
Pneumonia
Tend to hold breath
Wheezing
Sputum
Trouble breathing w/exercise

CARDIAC / VASCULAR

Arrhythmia
Chest pain
Heart trouble
Murmur
High blood pressure
Palpitations
Shortness of breath
Swollen feet or lower legs
Racing or pounding heart
Blood clots
Leg cramps
Poor circulation

MOUTH/THROAT

- Bleeding gums
- Dentures
- Tooth decay
- Frequent sore throats
- Grind teeth at night
- Hoarse voice/frequent loss of voice

NEUROLOGIC

- Blackouts
- Fainting
- Numbness
- Paralysis
- Dizziness
- Tremors
- Seizures

HEMATOLOGIC

- Anemia
- Bruise easily

ENDOCRINE

- Diabetes
- Excessive thirst or hunger
- Excessive sweating
- Lack of sweating
- Heat or cold intolerance
- Thyroid problem
- Hair loss
- Dizzy when standing/rising quickly
- Excessive weight loss
- Excessive weight gain

URINARY

- Frequent urination
- Blood in urine
- Incontinence
- Painful urination
- Urinate more than once at night

GASTROINTESTINAL

- Belching
- Flatulence/gas
- Black or tarry stools
- Blood in stool
- Change in stool
- Colitis
- Constipation
- Diarrhea
- Distention
- Excessive hunger
- Heartburn
- Food intolerance
- Hemorrhoids
- Indigestion
- Nausea
- Poor appetite
- Stomach pain
- Trouble swallowing
- Vomiting

PSYCHOLOGICAL

- Anxiety
- Depression
- Insomnia / hard to fall asleep
- Nervousness
- Poor memory / forget quickly
- Violent thoughts
- Suicidal ideas
- Tend to worry

MUSCLES & JOINTS

- Arthritis
- Tendonitis
- Bursitis
- Gout
- Trouble with/poor posture
- Chronic pain
- Pain with specific movement(s)
- Pain relieved with anti-inflammatory drugs (aspirin, ibuprofen, Vioxx, etc…)
- Pain, tenderness, or numbness in:
  - Neck
  - Shoulders
  - Arms
  - Elbows
  - Wrist/hands
  - Upper back
  - Lower back
  - Hips
  - Knees
  - Feet/ankles

SEXUAL/HORMONAL

- Bleeding between periods
- Decrease sexual interest
- Pain with intercourse
- Discharge
- Itching
- Sores
- Yeast infections
- Sexually Transmitted disease
- PMS
  - Breast tenderness
  - Cramping/bloating
  - Back Pain
  - Over-emotional
  - Tired/fatigue
  - Other pain
  - Other symptoms
- Age at first period _____
- Number of days in cycle _____
- Usual length of period _____
- Start of last menstrual period date ________________
- Number of pregnancies _____
- Number of deliveries _____
- Complications with pregnancies ____________________
- Birth control method ____________________

DIET HISTORY

How much do you drink each day **(8oz)**: Water:____ Juice: _____ Soda Diet: ____ Soda Regular: ____

Coffee: Regular: ____ Decaf: ____ Tea: Regular:____ Tea Sweet :____ Energy Drinks/Other: _______

List oils or fats that you use in cooking: ____

Do you frequently skip meals? Y N Are you on any special diet or nutrition program? Y N
Describe: ____

Are you allergic or sensitive to any foods? Y N If yes, name the foods and describe the problem.
____

What foods do you dislike? _________________________ What is/are your favorite food(s)?_________________________

Circle the foods you crave:
Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods
Spicy foods Sour foods Cereals Dairy Other individual ___________________

*Do you use: (circle) butter margarine shortening coconut oil *Do you eat organic foods? Y N

*Do you know what partially hydrogenated fats are? Y N __________If yes, do you eat them? Y N

*Do you eat from fast food restaurants? Y N -- If yes, how often? ____________

What do you usually eat for **breakfast**? ____

What do you usually eat for **lunch**? ____

What do you usually eat for **dinner**? ____

What do you usually eat for **snacks** (in between meals and/or before bed)? _______________________________________

What foods do you eat a lot of (at least once a day, every day)? ____

How many bowel movements do you have per day? ________

A Bit More ----

*Type of sport/activity/exercise routine you participate in:____

*Hours you train/exercise average per week: _________ *Do you train by yourself or with others? (circle)

*Do you use a heart rate monitor? Y N *What type of shoes do you wear? (Name/Style) _______________________

* Do you wear orthotics/arch supports/or any other devices during the day or when you exercise?

____

*Have you progressed, regressed, or plateaued in the past year? (circle)

*How many injuries (minor included) or illnesses do you suffer from per year? _________

*If applicable: When & what is your next competition you hope to participate in, or which one do you wish to "peak" for?