Women's Health Intake Form

Perfect Touch Massage & Chiropractic Ltd.

Dr. Nicole Klersy-Mohr D.C.

Name ____ Phone (   ) ___________________DOB______________

Address ____ City _________________________________

State _________ Zip__________ E-mail: ____

In case of emergency: ______________________________________ Phone (   )____________________________

Preferred method of contact: ____

Reason for your visit to Perfect Touch Massage & Chiropractic Ltd. today: (Check all that apply)

- ☐ Fertility Support
- ☐ Endometriosis/PCOS Care
- ☐ Primary Care
- ☐ Lab work/other diagnostics
- ☐ Nutritional Support
- ☐ Massage Therapy
- ☐ Manual Chiropractic Adjustments
- ☐ Other (explain): ______________________________

How did you hear about our office? ____

Were you referred by another health care provider? Yes / No   If Yes, who? ____________________________________

I understand and agree that the doctors at Perfect Touch Massage & Chiropractic Ltd. have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me was a patient.

Date ______________________________ **Signature** ______________________________

Physician's Signature: ____ **Date:** _________________

DOCTORS NOTES:

3101 Old Hwy 8, Suite 300, Roseville MN 55113

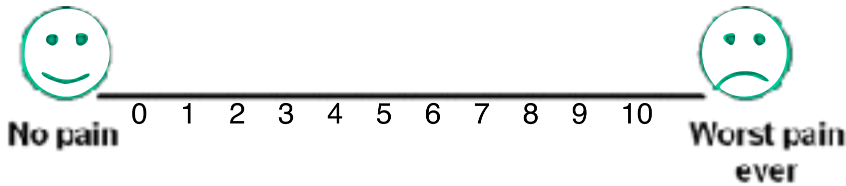
(651) 633-4291 | www.ptbodytherapy.com

If you have a musculoskeletal complaint today:

(if you are here about woman's health only, skip to female history on pg. 2)

What is your musculoskeletal complaint? ____

Is there pain associated with your complaint today? Yes / No If Yes, mark where that pain is on a scale from 0-10?

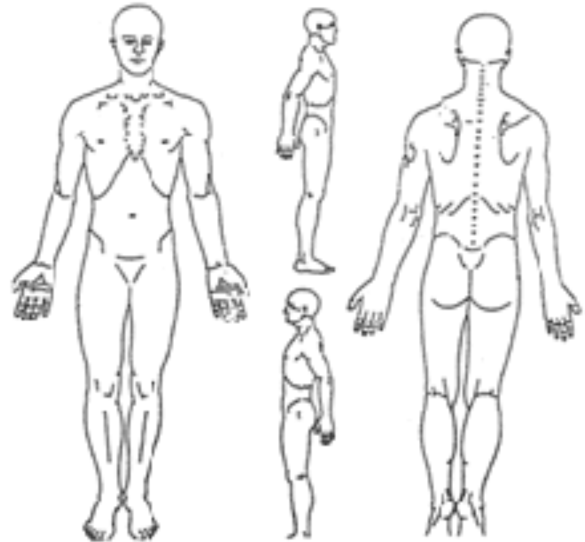


Please mark line on the left with an X

0 = No pain 10 = Worst pain ever

On the diagram to the right,
please mark the following symptoms,
if you are experiencing them:

"//" for stabbing pain,
"B" for burning pain,
"D" for dull pain,
"A" for aching
"N" in areas of numbness
"T" in areas of tingling
"St" in areas of stiffness
"Sw" in areas of swelling
"C" in areas of cramping



Have you seen anyone else for the **musculoskeletal** condition? Yes / No If Yes, who? ____________________

Have you missed work for this condition? Yes / No If Yes, how much? ____________________________

Have you tried any self-treatments for this condition? ____________________________________

If Yes, what makes it feel better?___________________________ feel worse?_______________________

Have you ever been treated for a similar problem? (If so please describe): _____________________________

____

Do you have any other complaints or concerns? ____

What do you think is causing your current musculoskeletal complaint? ______________________________

____

Past History

How do you feel that your health is overall? ____

Please list any/all past injuries, illnesses, surgeries & hospitalizations with dates of occurrence:______________

____

____

____

Have you had diagnostic tests? **(please check all that apply)**

- ☐ Blood labs (CBC, cholesterol, blood sugar, etc.)
- ☐ Urinalysis
- ☐ Pap smear (woman)
- ☐ Tuberculin test
- ☐ Stool sample
- ☐ Hormone panel (blood/saliva)
- ☐ Ultrasound (reproductive organs)
- ☐ Other: ___________________________

Where did you get these tests performed? ____

**If we need copies of your past tests we will discuss this with you at your next visit.*

Childhood Illness's (**please check all that apply**)

☐ Measles	Age: _____		☐ Polio	Age: _____
☐ Chicken pox	Age: _____		☐ Scarlet fever	Age: _____
☐ Rubella	Age: _____		☐ Rheumatic fever	Age: _____
☐ Whooping cough	Age: _____		☐ Other: (please list)_________________________	

Current Health History

Are you currently taking prescription or over the counter medications? (Please list them below including dosage)

1. ____________________	5. ____________________	9. ____________________
2. ____________________	6. ____________________	10. ____________________
3. ____________________	7. ____________________	11. ____________________
4. ____________________	8. ____________________	12. ____________________

Are you currently taking any herbs or nutritional supplements? (Please list them below)

1. ____________________	5. ____________________	9. ____________________
2. ____________________	6. ____________________	10. ____________________
3. ____________________	7. ____________________	11. ____________________
4. ____________________	8. ____________________	12. ____________________

Do you have any known allergies? (Please list them)

1. ____________________ 2. ____________________ 3. ____________________

Is your condition getting: **(circle)** Better | Worse | Staying the same

How have you handled your medical conditions in the past? **(circle all that apply)**

Medications | Nutrition/Diet | ER visit | Routine doctor visits | Chiropractic | Vitamins | Holistic care
Exercise | Other: ____

How was the outcome of above: **(circle one)**

Great | Okay | Bad | No change | Not sure | Only worked for a short time | Still trying | Did not get worse

What things in your life have been affected by this condition? (family/job/finances/marriage/future ability/sleep/time/freedom) ____

Have others been affected by your health condition? if so how…____

____

Are you concerned this health condition will develop into other issues? ____________________________

What has this problem cost you? (time/money/relationships/happiness/freedom/sleep/promotions/etc) ________________

____

Social & Environmental History

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you feel safe at home? Yes / No If you don't feel safe, do you have somewhere safe to go? Yes / No

Do you have a support system? Yes / No

Do you feel rested upon waking in the morning? Yes / No How many hours do you sleep each night? ________________

Do you get tired during the day and want to rest? Yes / No If yes, explain: ____________________________

____

What is a typical day look like for food consumption?

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Beverages: ____

What is your occupation? ____

Are you currently working with any materials you see that could be harmful? Yes / No If yes, list: ____________________

____

Have you worked with any materials that were harmful in the past? Yes / No If yes, list: ____________________________

____

Have you built a house and/or lived in a brand new house in the past 3 years? Yes / No

Do you wear your seatbelt in the car? Yes / No

Are you involved in sports, hobbies or special interests? Yes / No If yes, please list: ________________________________

____

Family History

Please check box and circle all that apply. (**Put the age they are currently if alive and age at time of death**):

- ☐ Mother Alive / Deceased AGE: _______
- ☐ Father Alive / Deceased AGE: _______
- ☐ Brother/Sister Alive / Deceased AGE: _______
- ☐ Brother/Sister Alive / Deceased AGE: _______
- ☐ Brother/Sister Alive / Deceased AGE: _______
- ☐ Brother/Sister Alive / Deceased AGE: _______
- ☐ Brother/Sister Alive / Deceased AGE: _______
- ☐ Brother/Sister Alive / Deceased AGE: _______
- ☐ Maternal Grandmother A / Dec. AGE: _______
- ☐ Maternal Grandfather A / Dec. AGE: _______
- ☐ Paternal Grandmother A / Dec. AGE: _______
- ☐ Paternal Grandfather A / Dec. AGE: _______
- ☐ Child Alive / Deceased AGE: _______
- ☐ Child Alive / Deceased AGE: _______
- ☐ Child Alive / Deceased AGE: _______
- ☐ Spouse Alive / Deceased AGE: _______

Does anyone in your family have: (**check all that apply**)

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Diabetes Type 2 (insulin dependent)
- ☐ Dementia/Alzheimer's Disease
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Kidney disease
- ☐ Cancer
- ☐ Arthritis
- ☐ Asthma
- ☐ Headaches
- ☐ Mental illness
- ☐ Epilepsy
- ☐ Alcoholism
- ☐ Drug addiction
- ☐ Thyroid Disease
- ☐ Autoimmune disease (Type:__________________)
- ☐ Anyone with similar symptoms as you today?

Where do you see your self 1 to 3 years if you do not address this health issue? ____________________________________

____

What would be better in your life if you had this health issue controlled? ____

____

What do you desire most from working with us? ____

____

____

____

Is there any other information you feel will be important for Dr. Nicole to know? (coping style, faith, etc.)_____________

____

____

____

____

____

Review of Systems

General
- ☐ Past / Present Weight loss/ gain
- ☐ Past / Present Fatigue
- ☐ Past / Present Fever or chills
- ☐ Past / Present Weakness
- ☐ Past / Present Trouble sleeping

Skin
- ☐ Past / Present Rashes
- ☐ Past / Present Lumps
- ☐ Past / Present Itching
- ☐ Past / Present Dryness

Head
- ☐ Past / Present Headache
- ☐ Past / Present Head injury
- ☐ Past / Present Neck pain

Ears
- ☐ Past / Present Decreased hearing
- ☐ Past / Present Ringing in ears
- ☐ Past / Present Earache
- ☐ Past / Present Drainage

Eyes
- ☐ Past / Present Vision Loss/ Changes
- ☐ Past / Present Glasses or contacts
- ☐ Past / Present Pain
- ☐ Past / Present Redness
- ☐ Past / Present Blurry or double vision
- ☐ Past / Present Flashing lights
- ☐ Past / Present Specks
- ☐ Past / Present Glaucoma
- ☐ Past / Present Cataracts
- ☐ Past / Present Last eye exam: __

Nose
- ☐ Past / Present Stuffiness
- ☐ Past / Present Discharge
- ☐ Past / Present Itching
- ☐ Past / Present Hay fever
- ☐ Past / Present Nosebleeds
- ☐ Past / Present Sinus pain

Throat
- ☐ Past / Present Bleeding
- ☐ Past / Present Dentures
- ☐ Past / Present Sore tongue
- ☐ Past / Present Dry mouth
- ☐ Past / Present Sore throat
- ☐ Past / Present Thrush
- ☐ Past / Present Non-healing sores

Neck
- ☐ Past / Present Lumps
- ☐ Past / Present Swollen glands
- ☐ Past / Present Pain
- ☐ Past / Present Stiffness

Breasts
- ☐ Past / Present Lumps
- ☐ Past / Present Pain
- ☐ Past / Present Discharge
- ☐ Past / Present Self-exams
- ☐ Past / Present Breast feeding (woman)

Respiratory
- ☐ Past / Present Cough
- ☐ Past / Present Sputum
- ☐ Past / Present Coughing up blood
- ☐ Past / Present Shortness of breath
- ☐ Past / Present Wheezing
- ☐ Past / Present Painful breathing

Cardiovascular
- ☐ Past / Present Chest pain or discomfort
- ☐ Past / Present Tightness
- ☐ Past / Present Palpitations
- ☐ Past / Present Shortness of breath (SOB) w/activity
- ☐ Past / Present Difficulty breathing lying down
- ☐ Past / Present Swelling
- ☐ Past / Present Sudden awakening from sleep w/SOB

Gastrointestinal
- ☐ Past / Present Swallowing difficulties
- ☐ Past / Present Heartburn
- ☐ Past / Present Change in appetite
- ☐ Past / Present Nausea
- ☐ Past / Present Change in bowel habits
- ☐ Past / Present Rectal bleeding
- ☐ Past / Present Constipation
- ☐ Past / Present Diarrhea
- ☐ Past / Present Yellow eyes or skin

Urinary
- ☐ Past / Present Frequency
- ☐ Past / Present Urgency
- ☐ Past / Present Burning or pain
- ☐ Past / Present Blood in urine
- ☐ Past / Present Incontinence
- ☐ Past / Present Change in urinary strength

Vascular
- ☐ Past / Present Calf pain with walking
- ☐ Past / Present Leg cramping

Musculoskeletal
- ☐ Past / Present Muscle or joint pain
- ☐ Past / Present Stiffness
- ☐ Past / Present Back pain
- ☐ Past / Present Redness of joints
- ☐ Past / Present Swelling of joints
- ☐ Past / Present Trauma

Neurologic
- ☐ Past / Present Dizziness
- ☐ Past / Present Fainting
- ☐ Past / Present Seizures
- ☐ Past / Present Weakness
- ☐ Past / Present Numbness
- ☐ Past / Present Tingling
- ☐ Past / Present Tremor

Hematologic
- ☐ Past / Present Ease of bruising
- ☐ Past / Present Ease of bleeding

Endocrine
- ☐ Past / Present Heat or cold intolerance
- ☐ Past / Present Sweating
- ☐ Past / Present Frequent urination
- ☐ Past / Present Thirst
- ☐ Past / Present Change in appetite

Psychiatric
- ☐ Past / Present Nervousness
- ☐ Past / Present Stress
- ☐ Past / Present Depression
- ☐ Past / Present Memory loss

Please check if currently using:
- ☐ Tobacco If yes, How many cigarettes/day? ________________ Age when started?__________
- ☐ Alcohol If yes, How often? ______________________How many drinks per occasion?______
- ☐ Recreational drugs

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Female History

Monarch (first menstrual cycle):

Age at first period: ______________________ How was the flow of your first period? (circle) Heavy | Moderate | Light

What was the duration (number of days/weeks) of your first period? ______________________________ | Don't Recall

What symptoms accompanied your first period? (please list) ____

____

Current Menstrual Cycle: (If you are no longer menstruating, please skip to menopause below.)

What age did your cycles become regular? ______________ | Not Regular Still, please explain:______________________

____

Cycle Length? ________ days. Describe flow of cycle: ____

How many tampons/pads will you go through during one menstrual cycle? ____

If this varies please explain: ____

Do you experience blood clots during a regular cycle? Yes | No If yes, describe: __________________________________

____

Has your menstrual cycle changed over the years? Yes | No If yes, explain: _____________________________________

____

Have symptoms changed as you have gotten older? Yes | No If yes, explain: _____________________________________

____

Menopause

What age did your menstruation start changing? ____________ What age did your menstruation stop? ________________

What age did your mother/sister(s) enter menopause? ____

Were there any complications in these months? Yes | No If yes, please describe: __________________________________

____

List any/all symptoms during the months going into menopause: ____

____

____

Has all these symptoms resolved since entering menopause? Yes | No If No, please describe: ______________________

____

____

Have you had a hysterectomy? Yes | No If yes, explain: ____

Any complications with this? Yes | No If yes, explain: ____

Fertility

Do you have any biological children? Yes | No If yes, how many? _____________ What ages? _____________________

Do your children have any health concerns? Yes | No If yes, please explain: _____________________________________

____

____

Are you trying to get pregnant? Yes | No If yes, how long have you been trying? __________________________________

Have you miscarried? Yes | No

How many times have you miscarried? __________ What term(s) did you miscarry at? ___________________________

Did you have to have a D&C or other procedure with your miscarriage? Yes | No If yes, what procedure? ____________

Any complications with the procedure? ____

Do you worry about fertility? Yes | No If yes, please explain: ______________________________

____

Does infertility run in your family? Yes | No If yes, please explain: ______________________________

____

____

Who have you seen about this in the past?______________________________

____

____

What treatments or procedures have you tried to get pregnant in the past? ______________________________

____

____

PCOS/Endometriosis

Do you have PCOS/PCOD? Yes | No

When were you diagnosed? ________________

What treatments or procedures have you tried for this? ______________________________

____

____

Did any of those treatments or procedures help? ______________________________

____

____

Do you have Endometriosis? Yes | No

When were you diagnosed? ________________

What treatments or procedures have you tried for this? ______________________________

____

____

Did any of those treatments or procedures help? ______________________________

____

____

Other Concerns

Are you on an exercise routine? Yes | No If yes, explain: ______________________________

____

How long have you been exercising for? ______________________________ days | months | years

Do you have a de-stress regimen? Yes | No If yes, how long? ______________________________

What does your de-stress regimen consist of? ______________________________

____

____

Do you have concerns about your spouse having infertility issues? Yes | No If yes, explain: ________________

____

____

Has your spouse been doing things for their health to prepare to conceive? Yes | No If yes, explain: ________________

____

____

____