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For Women only

How many pregnancies have you had _____? Number of deliveries _____

Were there any complications _____

What was pregnancy, labor and deliver like for you? _____

Did you nurse your babies? _____ If so, what was your impression of that
experience _____

Have you had any miscarriages? _____

Have you had any abortions? _____ If so, when _____

What medications did you mother take when she was pregnant with you? _____

Do any of the women on your mothers side of the family suffer from any of the following

Infertility _____ Menstrual problems _____ Difficult childbirth _____

Difficult menopause _____ Cancer _____ Heart trouble _____

YOUR menstrual pattern:

- Painful periods _____
- Late, early, or irregular _____
- Dark thick blood at onset or end of menstruation _____
- Dizziness with period _____
- Headache or migraine with period _____
- Excessive bleeding (more than one pad per hour) _____
- Blood clots during mnestruation _____
- PMS/Depression with or before period _____
- Failure to ovulate regularly _____
- Painful ovulation _____
- Bloating or water retention with period _____

Do you experience heaviness in the lower pelvis as menses begin _____

How many days does your period last _____

Do you experience no periods at all? _____ Explain _____

Check which other signs or symptoms apply:

- Varicose veins of the legs _____
- Tired weak legs _____
- Numb legs and feet especially when standing still _____
- Sore heels when walking _____
- Low back ache _____
- Painful intercourse _____
- Constipation _____
- Endometriosis _____
- Endometritis _____
- Uterine polyps _____

Uterine Fibroids _____
Uterine infections _____
Frequent urination _____
Bladder infections _____
Vaginal discharge (what color) _____
Vaginal yeast conditions/vaginitis _____
Chronic miscarriages _____
Premature deliveries _____
Weak newborn infants _____
False pregnancies _____
Difficult pregnancy, incompetent uterus, spotting _____
Pelvic inflammation _____
Sexually transmitted disease _____
Dry vagina with or without menopause _____
Difficult menopause _____
Cancer of the cervix, uterus, bladder, or lower bowel _____
Ovarian or breast cysts _____

List any other symptoms not included on list: _____

Do you remember if you had any serious falls or accidents in childhood or as an adult _____

Are you now or have you ever taken the birth control pill? _____ When and for how long _____

Do you or have you ever had fertility problems _____

Are you presently or have you recently been under the care of a doctor's care for gynecological problems _____

Rate your interest in sex:

High _____ Moderate _____ Low _____ None _____

Do you have difficulty achieving orgasms _____ Explain _____

Were you ever raped _____

At what age did this occur _____

Are you a survivor of incest _____

Have you undergone counseling for rape or incest _____

What was that like for you? Did it help? _____

Menopause: Check which of the following apply to you:

Hot flashes	_____	Memory loss	_____
Insomnia	_____	Mood swings	_____
Fatigue	_____	Vaginal discharge	_____
Depression	_____	Color of discharge	_____

More or less, when did these symptoms begin _____

Have you experienced a period every two weeks within the past few years _____

Have you taken estrogen replacement therapy _____

If so, for how long _____

List any herbal remedies, vitamins, supplements or natural products you are presently taking _____
