Nebraska KINESIOLOGY CENTER

AURORA
1619 9th St.
(402) 694-6501

KEARNEY
3504 2nd Ave.
(308) 237-2891

Welcome to the Nebraska Kinesiology Center. We are dedicated to providing you with personalized and preventive care to help you reach your health goals.

Initial visits include: a three part patient onboarding process. Each of the first three visits is scheduled as a thirty minute appointment, and is recommended to be scheduled within 7-10 days of the first visit. **Part 1** includes the initial consultation; applied kinesiologic and chiropractic structural exam; functional nutrition and food allergy analysis, neurological assessments, first structural treatment; and/or other necessary kinesiologic tests. **Part 2** includes a comprehensive review of the results of tests communication, functional nutrition recommendations, and treatment protocol recommendations review. **Part 3** includes a structural treatment and a comprehensive review of the neurological reset therapy and/or initial treatment.

Initial visit cost: is dependent on your insurance provider and extensiveness of the exam. New Patient exam fees are billed on a four level system, that range in cost from $50-$195, with the average adult new patient exam being about $100. The exam fee covers Part 1 and 2 exam and results of test communication appointments. It does not include any structural manipulations or therapies. Additional costs may include: specialized lab testing; nutritional supplements and homeopathic remedies; special programs; and/or orthopedic appliances.

NKC Health is a an insurance-based practice. However, coverage of chiropractic services by your insurance provider is specific to your provider and plan and is not guaranteed. Please take the time to identify with your insurance company and/or their provider webpages what types of services and therapies are covered. Insurance information is verified by our billing staff and payment for non-covered services is due at the time of service. However, we understand that life on a fixed income doesn't always allow for that, so monthly payment plans can be setup on an individual basis with our billing director. Your health is our priority, and we want to work with you to get you where you want to be. For your convenience, we accept cash, checks, Debit, Visa, Discover, MasterCard, and American Express. As a courtesy, we do provide our patients with a itemized fee sheet at time of service.

The following sheets are very important. Please answer all of the questions thoroughly at least three days before your appointment and bring them with you to your initial exam. Please wear comfortable clothing & shoes to your appointment.

IMPORTANT: Do not consume any nutritional supplements the day of your appointment. Also, we ask that you bring any medications and/or nutritional supplements (vitamins, herbs, oils, etc.) you deem necessary in your health routine. Out of respect for those patients who are sensitive, we also ask that you refrain from wearing any perfumes or colognes for your appointments in NKC Health Clinics.

We ask that you arrive 15 min. early to your initial appointment if you have the forms filled out ahead of time. If you are intending to fill out the paperwork in the clinic, please allow yourself at least 30 minutes in the building to accomplish it. Thank you for choosing Nebraska Kinesiology Center for your healthcare needs.

Patient Signature _____ **(or Guardian) Date** _____

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Mandatory Disclosures

Informed Consent for Chiropractic Treatment

Chiropractic adjustments are a conservative and very safe procedure. We are required by law to notify you of any risk involved. The only serious complication of a chiropractic adjustment is a vertebral artery injury, commonly known as a stroke. It is extremely rare – statistics show this may occur about once in a million to once in 10 million adjustments. Most importantly, there has never been a case of vertebral artery injury at this clinic.

_____ I understand the remote possibility of injury from chiropractic treatment and elect to receive the recommended treatment.

Privacy Policies and Authorizations

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED/DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We have always been very concerned with protecting your privacy, but now the federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This notice will remain in effect until further notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information within this clinic in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities such as reviewing office procedures and training staff. Patient information will be disclosed in hard-copy only. No fax or internet transmissions will be sent.

We may also disclose your health information with your written consent. Your authorization may be revoked in writing at any time. Your revocation will take effect upon receipt. Any authorization you have signed that we receive from any other source will also be considered valid.

Your Family and Persons Involved in Your Care: We ask that patients take responsibility to make and cancel their own appointments, except in the case of minors or disadvantaged adults. We confirm your appointment time by telephone and may leave a message on either a voicemail or with another person in your household if you are not available. We will also use our professional judgment when allowing another person to pick up supplements or requested information relayed on your behalf.

You have the right to get a copy of your health record by giving us a written request. We reserve the right to charge for copying costs at a rate of $.90 per page and a $12.00 retrieval fee. You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging I have received a copy of this authorization.

_____	_____	_____
Patient Name Patient	Patient Signature	Signature Date

_____	_____
Personal Representative	Personal Representative Signature

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PATIENT WITH INSURANCE ELECTION TO SELF PAY FOR SERVICES

I, _____, the undersigned patient, acknowledge that I understand and agree that:
1. Nebraska Kinesiology Center is a participating provider with _____.
2. I am covered by one of the _____ health insurance plans.
3. The health plan under which I am covered includes benefits for some or all of the services provided by Nebraska Kinesiology Center.
4. Despite the above, I do not wish to submit a claim to _____ for services provided to me by Nebraska Kinesiology Center.
5. Until such time as I may otherwise advise Nebraska Kinesiology Center in writing, I elect to pay for all services I receive from Dr. Joel Martenson at Nebraska Kinesiology Center.
6. By election to self-pay for services, any payments I make to Nebraska Kinesiology Center will not be credited toward satisfying any deductible I may be subject to under my health insurance plan with _____.
7. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.
8. I have freely chosen to self-pay for services after having asked Nebraska Kinesiology Center about payment options and having carefully considered those options.
9. I understand I am responsible for payment of my account balance.

PATIENT ELECTION TO SUBMIT TO INSURANCE

I, _____, the undersigned patient, acknowledge that I understand and agree that:
1. Nebraska Kinesiology Center is a participating provider with _____.
2. I am covered by one of the _____ health insurance plans.
3. The health plan under which I am covered includes benefits for some or all of the services provided by Nebraska Kinesiology Center.
4. I do wish to submit a claim to _____ for services provided to me by Nebraska Kinesiology Center .
5. I understand I am responsible for payment of my account balance not paid by my health insurance.

PATIENT NO INSURANCE/ NON PPO SELF PAY

I, _____, the undersigned patient, acknowledge that I understand and agree that:
1. Nebraska Kinesiology Center is a nonparticipating provider with my insurance carrier or I do not have current medical coverage at this time.
2. I elect to pay for all services I receive from Dr. Joel Martenson at Nebraska Kinesiology Center.
3. I have freely chosen to self-pay for services after having asked Nebraska Kinesiology Center about payment options and having carefully considered those options.
4. I understand I am responsible for payment of my account balance.

Date: _____ Patient: _____ Signature of patient or responsible party if patient is a minor or
Witness: _____ Date: _____

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New Patient Evaluation

Please complete the following questions carefully. This information will help us to build a personalized wellness program for you. Information you provide is strictly confidential.

DO NOT TAKE ANY NUTRITIONAL SUPPLEMENTS ON THE DAY OF YOUR EXAM

Initial Visit Date & Time: _____
Name: _____ Birth date: _____/_____/_____ Age: _____ M | F
Address: _____City: _____State: _____ Zip: _____
Phone (circle preferred contact): Home: _____ Cell: _____
Email: _____Would you like to receive our emails? Y | N
Preferred Method of Contact (circle one): Email | Phone | Text | All
Do you have Medicare benefits? Y | N
Marital Status: Single | Married | Divorced | Widowed No. of Children: _____
Occupation:_____
Referred by: _____ Is it ok to contact this person? Y | N

Patient Health Assessment

Please list the current health **conditions/symptoms/injuries** that concern you.

_____ _____

_____ _____

_____ _____

1. Next to the conditions/symptoms/injuries above **rate the severity** on a scale from 1 to 10 (10 being the most severe).
2. **Type:** Achy Burning Dull Sharp Stiff Throbbing Other:_____
3. **How often** you experience the conditions/symptoms?

   0-10 10-20 20-30 30-40 40-50 50-60 60-70 70-80 80-90 100 %
4. **How** did the initial conditions/symptoms/injury occur? _____
5. **When** did the injury occur?_____
6. **Are the conditions/symptoms/injury:** Improving Getting Worse No Change **since onset.**
7. **Does the pain**/condition/symptom **travel** into an extremity? *If Yes, Explain:* _____
8. **Past History:** On & Off for Years Years Ago
9. **Have you seen another physician for this condition/symptom/injury?** *If Yes, Explain:*

_____

10. **When** does it **feel worse**?

    No Change Morning As Day Progresses Afternoon Evening During the Night

11. **What** makes it **feel worse?**

    Nothing Resting Sleeping Walking Working Movement Other: _____

12. **When** does it **feel better**?

    No Change Morning As Day Progresses Afternoon Evening During the Night

13. **What** makes it **feel better**?

    Nothing Cold Chiropractic Massage Medication Movement Resting Sleeping Walking Warmth

    Other:_____

14. Is there any **daily activity** you are **unable to perform or had to modify** due to this condition, symptom, or injury? Y | N *If Yes, Explain:* _____

15. **Nutritional Supplements:** Please list any nutritional supplements/products you are currently using.

    _____

    _____

    _____

16. **Medications:** Please list any medications you are currently taking and how long you have taken them (including birth control pills, aspirin, pain medication, sleep aids, etc.)

    _____

    _____

    _____

    _____

    _____

17. **Surgeries:**

    Have you ever had full-body anesthesia (wisdom teeth, to remove tonsils, etc.)? Y | N

    Do you have breast implants? Y | N

    Other surgical implants or prostheses? Y | N

    Have you had elective surgery (tummy tuck, face-lift, mole removal, etc)? Y | N

    Do you have any internal metal or plastic (such as pins, clamps, plates, etc)? Y | N

Do you have body piercings or tattoos? Y | N *Explain:*

_____

_____

18. **Stress:** Please rate your current stress level on a scale of (1 to 10) 10 being the highest stress:_____

    Please list the 5 most stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life or your health?

    a._____

    b._____

    c._____

    d._____

    e._____

    What step(s) are you taking to reduce your stress level?

    _____

    _____

    _____

    _____

19. **Sleep:** How is your sleep? (check all that apply)

    ☐ I sleep very well ☐ Restless ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Bad dreams

    ☐ I wake feeling rested ☐ I wake feeling tired ☐ Other:_____

    How many times per night do you wake up? _____

    What time do you usually go to sleep? _____

    How many hours of sleep do you get per night? _____

    How many times per night do you wake to urinate? _____

    What are your hopes and goals for your health in the next 6-12 months?

    _____

    _____

    _____

20. **Exercise:** What kind of exercise do you enjoy on a frequent basis?

    _____

    _____

_____

How often? _____ For how long at a time? _____

Conditions & Symptoms Assessment

Please Check and/or Describe All That Apply:

1st Box = Past. 2nd Box = Present.

Muscular-Skeletal

- ☐ ☐ Pain or Aches in Joints
- ☐ ☐ Arthritis
- ☐ ☐ Feeling of Weakness or Tiredness
- ☐ ☐ Neck Pain
- ☐ ☐ Pain Between Shoulders
- ☐ ☐ Low Back Pain
- ☐ ☐ Arm Problems
- ☐ ☐ Leg Problems
- ☐ ☐ Swollen Joints
- ☐ ☐ Painful Joints
- ☐ ☐ Stiff Joints
- ☐ ☐ Sore Muscles
- ☐ ☐ Weak Muscles
- ☐ ☐ Walking Problems

Neuro-Emotional

- ☐ ☐ Numbness
- ☐ ☐ Loss of Feeling
- ☐ ☐ Dizziness
- ☐ ☐ Faintness
- ☐ ☐ Headaches
- ☐ ☐ Muscle Jerking
- ☐ ☐ Poor Memory
- ☐ ☐ Confusion
- ☐ ☐ Poor Concentration
- ☐ ☐ Poor Comprehension
- ☐ ☐ Depression
- ☐ ☐ Insomnia
- ☐ ☐ Learning Disabilities
- ☐ ☐ Stuttering or Stammering
- ☐ ☐ Poor Physical Coordination
- ☐ ☐ Mood Swings
- ☐ ☐ Anger, Irritability, Aggressiveness
- ☐ ☐ Anxiety, Fear, Nervousness

Cardio-Vascular-Respiratory

- ☐ ☐ Chest Pain
- ☐ ☐ Irregular or Skipped Beat
- ☐ ☐ Rapid Pounding Heartbeat
- ☐ ☐ Pain Over Heart
- ☐ ☐ Chest Congestion
- ☐ ☐ Asthma, Bronchitis
- ☐ ☐ Shortness of Breath
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Persistent Cough (Next Column →)
- ☐ ☐ Coughing Phlegm
- ☐ ☐ Coughing Blood
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Heart Problems
- ☐ ☐ Varicose Veins
- ☐ ☐ High Cholesterol (> 250)
- ☐ ☐ Low Cholesterol (< 150)

Gastro-Intestinal

- ☐ ☐ Bloated Feeling
- ☐ ☐ Belching, Passing Gas
- ☐ ☐ Poor Appetite
- ☐ ☐ Excessive Hunger
- ☐ ☐ Difficulty Chewing
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Excessive Thirst
- ☐ ☐ Nausea
- ☐ ☐ Vomiting Food
- ☐ ☐ Abdominal Pain
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Black Stool
- ☐ ☐ Bloody Stool
- ☐ ☐ Hemorrhoids
- ☐ ☐ Heartburn

How many bowel movements do you average per day? _____

Urinary System

- ☐ ☐ Excessive Urination
- ☐ ☐ Scanty Urination

- ☐ ☐ Painful Urination
- ☐ ☐ Discolored Urination
- ☐ ☐ Frequent UTI's

Eyes
- ☐ ☐ Watery or Itchy
- ☐ ☐ Bags or Dark Circles Under Eyes
- ☐ ☐ Swollen, Reddened, or Sticky Eyelids
- ☐ ☐ Blurred or Tunnel Vision

Ears
- ☐ ☐ Itchy Ears
- ☐ ☐ Earaches/Infections
- ☐ ☐ Drainage from Ear
- ☐ ☐ Ringing in Ears

Nose
- ☐ ☐ Stuffy Nose
- ☐ ☐ Sinus Problems
- ☐ ☐ Hay Fever
- ☐ ☐ Sneezing Attacks
- ☐ ☐ Excessive Mucus

Mouth/Throat
- ☐ ☐ Heartburn
- ☐ ☐ Chronic Coughing
- ☐ ☐ Gagging, Frequent Need to Clear Throat
- ☐ ☐ Sore Throat, Hoarseness, Loss of Voice
- ☐ ☐ Swollen or Discolored Tongue, Gums, Lips
- ☐ ☐ Canker Sores

Skin
- ☐ ☐ Acne
- ☐ ☐ Hives, Rashes, Dry Skin
- ☐ ☐ Hair Loss
- ☐ ☐ Flushing, Hot Flashes
- ☐ ☐ Excessive Sweating

Energy/Activity
- ☐ ☐ Difficulty in Making Decisions
- ☐ ☐ Fatigue, Sluggishness
- ☐ ☐ Apathy, Lethargy
- ☐ ☐ Hyperactivity
- ☐ ☐ Restlessness

Weight
- ☐ ☐ Underweight
- ☐ ☐ Binge Eating/Drinking
- ☐ ☐ Craving Certain Foods
- ☐ ☐ Excessive Weight Gain
- ☐ ☐ Water Retention
- ☐ ☐ Compulsive Eating

Other
- ☐ ☐ Frequent Illness

Family History *Please Check and/or Describe All That Apply:*

Do any of your family members have (or have they had) any of the following diseases or conditions?

- ☐ Abnormal Bleeding/Hemophilia
- ☐ Gastrointestinal Disorders
- ☐ Anemia
- ☐ Heart Problems
- ☐ Arthritis
- ☐ Heart Murmur
- ☐ Asthma/Hay Fever
- ☐ Hepatitis/ Liver Problems
- ☐ Bone Disorders
- ☐ High/Low BP
- ☐ Cancer – *Please Specify*:_____
- ☐ Tuberculosis
- ☐ Kidney Problems
- ☐ Chronic Back Pain
- ☐ Lupus
- ☐ Chronic Headaches
- ☐ Nervous Disorder
- ☐ Congenital Heart Defect

- ☐ Obesity
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Major Surgeries: _____
- ☐ Other: _____

Food Choices

1. Meal Habits

Do you: ☐ Skip meals often? ☐ Have irregular eating times? ☐ Eat food past 9pm?

What percentage of the meat you purchase is organic? _____

What percentage of the produce you purchase is organic? _____

Please indicate how many days per week you consume the following:

- ☐ Frozen dinners
- ☐ Red meat
- ☐ Chicken or Turkey
- ☐ Fish
- ☐ Pork
- ☐ Fresh Vegetables
- ☐ Fresh Fruit
- ☐ Frozen or Canned Fruit
- ☐ Frozen or Canned Vegetables
- ☐ Wild Game
- ☐ Eggs
- ☐ Pasta
- ☐ Rice
- ☐ Boxed Cereals

Do you eat at restaurants? Y | N If yes, how often? _____

Do you prepare meals at home? Y | N If yes, how often? _____

How many times per week do you cook or reheat your food in a microwave? _____

2. Water

Do you drink tap water? Y | N

Do you use a water filter at home? Y | N If yes, what brand?_____

Do you buy purified drinking water? Y | N If yes, what brand? _____

3. **Food Stressors** Please indicate how many **days per week** you consume the following foods:

Stimulants

_____ Coffee
_____ Black Tea
_____ Soft Drinks
_____ NutraSweet Drinks
_____ Alcohol
_____ Chocolate
_____ Candy or Sweets

Toxic Oils

_____ Fried Foods
_____ Fast Food
_____ Potato Chips
_____ Roasted Nuts
_____ Mayonnaise
_____ Margarine
_____ Peanut Butter

Commercial Dairy

_____ Cow's Milk
_____ Yogurt
_____ Ice Cream
_____ Cottage Cheese
_____ Sour Cream
_____ Cheese

Highly Heated Foods

_____ Bread
_____ Crackers
_____ Bagels
_____ Muffins
_____ Cookies - Pastries

4. **Food Chart** Please list everything you eat and drink for 2 days:

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						

Toxic Exposure

1. **Smoking**
   Do you currently smoke? Y | N If yes, how much? _____
   How long have you smoked (currently or in the past)? _____

2. **Drugs**
   Do you currently use recreational drugs (ex. marijuana, cocaine, uppers, downers)? Y | N
   If yes, which ones, and how often? *Reminder: This is strictly confidential information.*
   _____
   _____

3. **Personal Care and Home Products** Please check all that you use:
   - ☐ Hair Perm
   - ☐ Antiperspirant
   - ☐ Facial Make-Up
   - ☐ Hair Spray
   - ☐ Air Fresheners (spray)
   - ☐ Air Fresheners (plugins)
   - ☐ Hair Gel
   - ☐ Dryer Sheets
   - ☐ Roach/Ant Spray
   - ☐ Hair Color - Semi or Permanent
   - ☐ Toilet Freshener
   - ☐ Fingernail Polish
   - ☐ Perfume/Cologne
   - ☐ Lawn Fertilizer (Non-Organic)

   What type of mattress do you sleep on?
   _____

   Do you work with or near chemicals? Y | N
   Explain: _____

   Do you have metal fillings? Y | N How many? _____

4. **Appliances** Please check all that you use:
   - ☐ Gas Stove
   - ☐ Electric Stove
   - ☐ Electric Heater
   - ☐ Electric Blanket
   - ☐ Water Bed
   - ☐ Microwave Oven
   - ☐ Non-Stick Cookware
   - ☐ Air Purifier - What Brand? _____

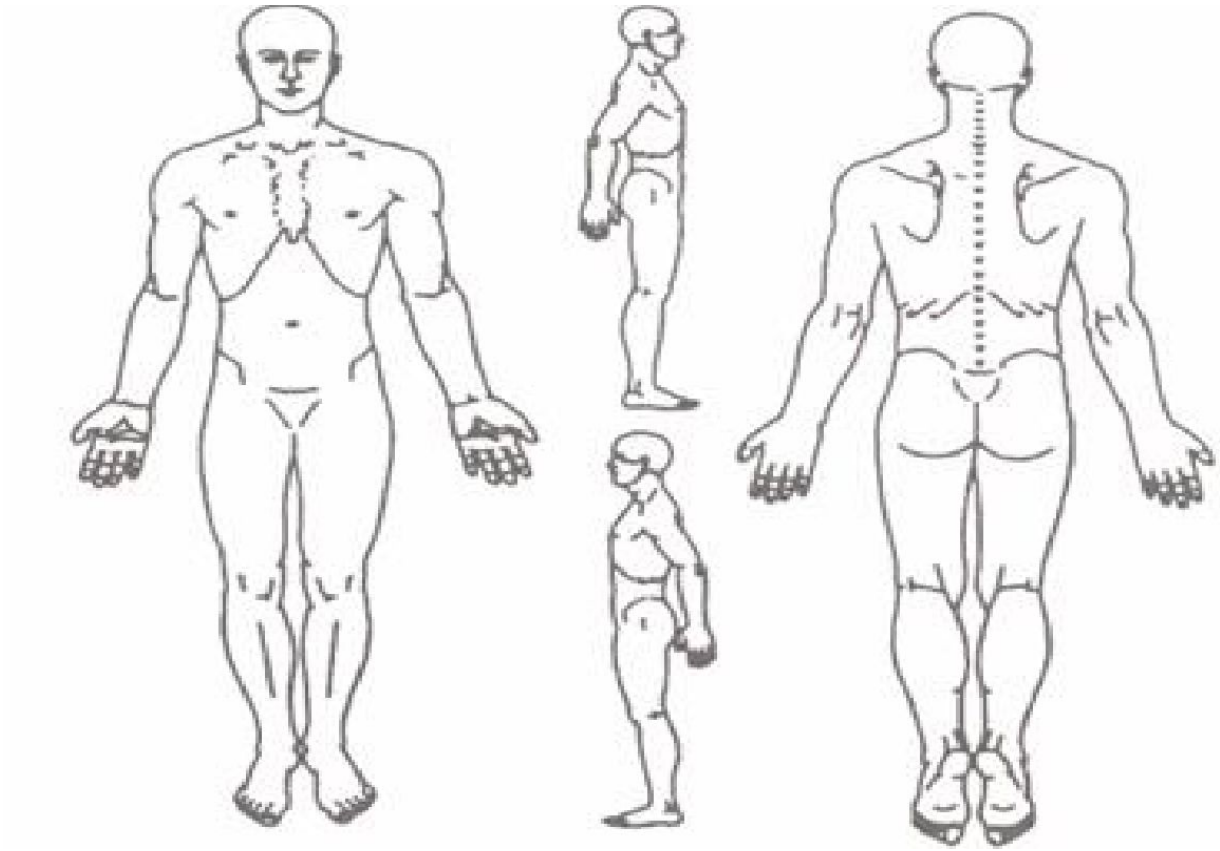
5. **Pets**
   Do you have a pet? Y | N If yes, what kind and how many? _____

   Is the pet allowed in the house? Y | N On your bed? Y | N

6. **Electromagnetic Exposure**
   Do you live or work near high voltage power lines? Y | N
   How many hours do you spend daily:

_____ Watching TV
_____ Working on a Computer
_____ Talking on a Phone
_____ Wearing a Pager

_____ Wearing a Wrist Watch
_____ Wearing a Hearing Aid
_____ In a Car
_____ Near Electrical Equipment
_____ Near a Clock Radio



Symptoms & History Chart

Please read and follow the directions below carefully.

Type of Current Pain: *Label the type of current condition/symptom on the diagram using guide.*
A= Ache **B=** Burning **C=** Cramping **D=** Dull pain **R=** Throbbing **N=** Numbness **T=** Tingling **S=** Stiffness

All Scars: Please draw a blue line "---"on the drawing where you have scar, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, etc.

All Trauma Areas: Please put a red "**X**" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle "**O**" on the drawing if you have any type of internal metal objects, such as surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date & Type of Injury: Draw a line from each of the above injury areas and print the type of injury and approximate date of injury.

Women's Health Screen

Are you pregnant? Y | N
Are you nursing? Y | N
Have you had a hysterectomy? Y | N If yes, when? _____
Do you have monthly periods? Y | N
Date of last menstrual cycle (1st day of flow) _____
Number of C-Sections: _____
Number of episiotomies or muscle tears: _____

Check the symptoms you experience regularly one to two weeks before your period:

- ☐ Anxiety
- ☐ Irritability
- ☐ Nervous Tension
- ☐ Aggressive or Hostility
- ☐ Self Destructive Behavior
- ☐ Weight Gain
- ☐ Water Retention
- ☐ Abdominal Bloating
- ☐ Tender, Swollen, &/or Painful Breasts
- ☐ Breast Lumps that Increase in Size & Tenderness
- ☐ Discharge from Nipples
- ☐ Craving for Sweets
- ☐ Increased Appetite
- ☐ Heart Palpitations
- ☐ Fatigue
- ☐ Headaches
- ☐ Shaky or Clumsy
- ☐ Depression
- ☐ Withdrawn
- ☐ Confusion
- ☐ Forgetfulness
- ☐ Insomnia/Difficulty Sleeping

Check the symptoms of behaviors that occur during your period:

- ☐ Cramping in the Lower Abdominal or Pelvic Area
- ☐ Sharp Intermittent Pain
- ☐ Dull Aching Pain
- ☐ Upset Stomach
- ☐ Diarrhea
- ☐ Nausea or Vomiting
- ☐ Low Back Aches
- ☐ Headaches
- ☐ Difficulty Concentrating
- ☐ Accident Prone
- ☐ Unusual Fatigue
- ☐ Decrease Productivity
- ☐ Weight Gain
- ☐ Painful and/or Swollen Breasts
- ☐ Irritability
- ☐ Mood swings
- ☐ Depression
- ☐ Painful Intercourse

Check any of the following statements that describe your menstrual cycle, energy level, or reproductive function:

- ☐ Heavy Prolonged Menstrual Bleeding/Clotting
- ☐ Menstrual Bleeding Longer than 5 Days
- ☐ Absence of Periods for 3 Months or More
- ☐ Vaginal Itching, Burning, or Dryness
- ☐ Frequent Menstruation (Cycle is < 21 days)
- ☐ Irregular Periods (Once Every 3-6 Months)
- ☐ Frequently Skip Periods
- ☐ Menstrual Cycle Every 36 days or Longer
- ☐ Unusually Light or Heavy Periods
- ☐ Consistent Unusually Light Menstrual flow
- ☐ Menses Last Three days and are Light
- ☐ Bleeding or Spotting Between Periods
  - ☐ ... and is Light
  - ☐ ... and is Heavy
- ☐ Abnormal Vaginal Discharge
- ☐ Frequent Urination

Check any of the following symptoms if they occur throughout the month:

- ☐ Decline of Vital Energy and Sense of Well-Being
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Spontaneous Sweating
- ☐ Chills
- ☐ Depression
- ☐ Irritability
- ☐ Anxiety
- ☐ Anger
- ☐ Mood Swings
- ☐ Headaches
- ☐ Forgetfulness
- ☐ Difficulty Concentrating
- ☐ Difficulty Sleeping

- ☐ Urinary Problems
- ☐ Vaginal Problems
- ☐ Dry Skin
- ☐ Bleeding Between Periods
- ☐ Irregular Periods
- ☐ Stopped Menstruating
- ☐ Joint and Muscle Pain
- ☐ Change in Sexual Desire
- ☐ Difficulty with Orgasm
- ☐ Painful Intercourse
- ☐ Loss of Muscle Tone
- ☐ Vaginal Bleeding Any Time
- ☐ Vaginal Bleeding After Intercourse
- ☐ Vaginal Discharge