Adult Medical/Mental Health Questionnaire

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

Name:____ Date:___________________

Address:__________________________________ City:_____________ State:_______Zip:________

Home Phone: (______) _____-____________ Birth Date: _____/_____/_____ Age: _________

Work Phone: (______) _____-____________ Place of Birth: ________________________________

Occupation: ________________________ City or town & country if not US

Referred by: ________________________ Height: ___‘ _____“ Weight: _________ Sex: _______

Please check appropriate box(es):

- ☐ African American
- ☐ Native American
- ☐ Hispanic
- ☐ Caucasian
- ☐ Mediterranean
- ☐ Northern European
- ☐ Asian
- ☐ Other

1. Please state the principal reason you are requesting consultation or treatment and describe your condition, from the time of your first symptom to the present.

____
____
____
____
____
____
____
____
____
____
____
____
____

2. Please rank current and ongoing symptoms/problems by severity and fill in the other boxes as completely as possible:

Describe Symptom/Problem	**Mild/ Moderate/ Severe**	**Treatment Approach**	**Success**
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

Emergency Contact Name and Relationship: ____

Alternate Phone: (_____) ____________

Name of person filling out form, if not patient: ____________________________ Relationship: _______________

4. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)____
____
____

5. Do you have any pets or farm animals? Yes___ No ___
If yes, where do they live? ______Indoors _______Outdoors ______ Both

6. Have you lived or traveled outside of the United States? Yes __ No __
If so, when and where? ____

7. Have you or your family recently experienced any major life changes? Yes __ No __
If yes, please comment: ____

8. Have you experienced any major losses in life? Yes __ No __

If yes, please comment: ____

9. How important is religion (or spirituality) for you and your family's life?
a. _____ Not at all important
b. ____ Somewhat important
c. _____ Extremely important

10. How much time have you lost from work or school in the past year?

a. ____ 0-2 days
b. ____ 3-14 days
c. ____ > 15 days

11. Previous jobs: ____

12. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

a. Did you feel safe growing up? Yes __ No __
b. Have you been involved in abusive relationships in your life? Yes __ No __
c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships? Yes __ No __
d. Do you currently feel safe in your home? Yes __ No __
e. Do you feel safe, respected and valued in your current relationship? Yes __ No __
f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse? Yes __ No __

13. Past Medical and Surgical History:

ILLNESSES	WHEN	COMMENTS
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Chrohn’s Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, convulsions, or seizures		
k. Gallstones		

	ILLNESSES	WHEN	COMMENT
l.	Gout		
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	INJURIES	**WHEN**	**COMMENTS**
a.	Back injury		
b.	Broken (describe)		
c.	Head injury		
d.	Neck injury		
e.	Other (describe)		

	DIAGNOSTIC STUDIES	WHEN	COMMENTS
a.	Barium Enema		
b.	Bone Scan		
c.	CAT Scan of Abdomen		
d.	CAT Scan of Brain		
e.	CAT Scan of Spine		
f.	Chest X-ray		
g.	Colonoscopy		
h.	EKG		
i.	Liver scan		
j.	Neck X-ray		
k.	NMR/MRI		
l.	Sigmoidoscopy		
m.	Upper GI Series		
n.	Other (describe)		
	OPERATIONS	**WHEN**	**COMMENTS**
a.	Appendectomy		
b.	Dental Surgery		
c.	Gall Bladder		
d.	Hernia		
e.	Hysterectomy		
f.	Tonsillectomy		
g.	Other (describe		

14. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON

15. How often have you taken antibiotics?

	< 5 times	**> 5 times**
Infancy/Childhood		
Teen		
Adulthood		

16. How often have you taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	**> 5 times**
Infancy/Childhood		
Teen		
Adulthood		

17. What medications are you taking now? Include non-prescription drugs please.

Medication Name	**Date Started**	**Dosage**

18. Are you allergic to any medications? Yes ___ No ___
If yes, please list them: ____
____

19. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	**Date Started**	**Dosage**

20. Childhood:	**Yes**	**No**	**Don't Know**	**Comment**
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

21. As a child, were there any foods that you had to avoid because they gave you symptoms? Yes___No___
If yes, please list the food and symptom (Example: milk-gas and diarrhea)

____
____
____

22. Place a check mark next to the food/drink that applies to your current diet.

✓	**Usual Breakfast**	✓	**Usual Lunch**	✓	**Usual Dinner**
	None		None		None
	Bacon/Sausage		Butter		Beans (legumes)
	Bagel		Coffee		Brown Rice
	Butter		Eat in a cafeteria		Butter
	Cereal		Eat in a restaurant		Carrots
	Coffee		Fish Sandwich		Coffee
	Donut		Juice		Fish
	Eggs		Leftovers		Green Vegetables
	Fruit		Lettuce		Juice
	Juice		Margarine		Margarine
	Margarine		Mayo		Milk
	Milk		Meat Sandwich		Pasta
	Oat Bran		Milk		Potato
	Sugar		Salad		Poultry
	Sweet Roll		Salad Dressing		Red Meat
	Sweetener		Soda		Rice
	Tea		Soup		Salad
	Toast		Sugar		Salad Dressing
	Water		Sweetener		Soda
	Wheat Bran		Tea		Sugar
	Yogurt		Tomato		Sweetener
	Other: (List below)		Water		Tea
			Yogurt		Water
			Other: (List below)		Yellow Vegetables
					Other: (List below)

23. How much of the following do you consume each week?

a. Candy		d. Coffee with Caffeine		g. Diet Sodas		j. White bread	
b. Cheese		e. Decaf Coffee/Tea		h. Ice cream		k. Soda w/ Caffeine	
c. Chocolate		f. Hot Chocolate		i. Salty foods		l. Soda w/out Caffeine	

24. Are you on a special diet? Yes ___ No ___

_____ovo-lacto _____vegetarian _____other (describe)
_____diabetic _____vegan ____________________
_____dairy restricted _____blood type diet ____________________

25. Is there anything special about your diet that we should know? Yes ___ No___
If yes, please explain: ____

26. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.? Yes ___ No ___

b. If yes, are these symptoms associated with any particular food or supplement(s)? Yes ___ No ___

c. Please name the food or supplement and symptom(s). (Example: Milk- gas and diarrhea)

____

____

27. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes ___ No ___

28. Do you feel much **worse** when you eat a lot of:

_____ high fat foods _____ refined sugar (junk food) _____ high protein foods
_____ fried foods _____ high carbohydrate foods (breads, pastas, potatoes) _____ 1 or 2 alcoholic drinks
_____ other

29. Do you feel much **better** when you eat a lot of:

_____ high fat foods _____ refined sugar (junk food) _____ high protein foods
_____ fried foods _____ high carbohydrate foods (breads, pastas, potatoes) _____ 1 or 2 alcoholic drinks
_____ other

30. Does skipping a meal greatly affect your symptoms? Yes ___ No ___

31. Have you ever had a food that you craved or really "binged" on over a period of time?

Food craving may be an indicator that you may be allergic to that food. Yes ___ No ___

If yes, what food(s)?____

____

32. Do you have an aversion to certain foods? Yes ___ No ___

If yes, what food(s)?____

____

33. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard & loose/watery			

34. Intestinal gas: ____Daily ____ Present with pain
____Occasionally ____ Foul smelling
____Excessive ____ Little odor

35. a. Have you ever used alcohol? Yes ___ No ___
If yes, how often do you now drink alcohol?
______ No longer drinking alcohol
______ Average 1-3 drinks/week
______ Average 4-6 drinks/week
______ Average 7-10 drinks/week
______ Average > 10 drinks/week

b. Have you ever had a problem with alcohol? Yes ___ No ___
If yes, please indicate time period (month/year): From _______to ____.

36. Have you ever used recreational drugs? Yes ___ No ___
37. Have you ever used tobacco? Yes ___ No ___
If yes, number of years as a nicotine user _________. Amount per day ____. Year quit ___.
If yes, what type of nicotine have you used? ______ Cigarette____ Smokeless___ Cigar
______ Pipe ________ Patch/Gum
38. Are you exposed to second hand smoke regularly? Yes ___ No ___
39. Do you have mercury amalgam fillings? Yes ___ No ___
40. Do you have any artificial joints or implants? Yes ___ No ___
41. Do you feel worse at certain times of the year? Yes ___ No ___
If yes, when? ______Spring ______ Fall
______Summer _____Winter

42. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes ___ No ___
If yes, which one(s)? ______ Lead ______Cadmium ______ Arsenic
______ Mercury ______ Aluminum
43. Do odors affect you? Yes ___ No ___

44. How well have things been going for you?

	Very Well	**Fair**	**Poorly**	**Very Poorly**	**Doesn’t Apply**
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boy/girl-friend					
h. With your children					
i. With your parents					
j. With your spouse					

45. Have you ever had psychotherapy or counseling? Yes ___ No ___
Currently? ___ Previously?___ If previously, from ___to___.
What kind?____
Comments:____

46. Past Psychiatric Medications (Prescription and Herbal)

Please review the following list of commonly prescribed psychotropics. Both the trade name and the generic name of each has been provided to aid in your recollection. Box is continued on next page.

Name	Took in Past	Particularly Helpful	Caused Side Effect (specify)
Prozac/Fluoxetine			
Paxil/Paroxetine			
Zoloft/Sertraline			
Celexa/Citalopram			
Lexapro/Escitalopram			
Luvox/Fluvoxamine			
Wellbutrin/Buproprion			
Serzone/Nefazodone			
Effexor/Venlafaxine			
Remeron/Mirtazepine			
Cymbalta/Duloxetine			
Risperdal/Risperidone			
Zyprexa/Olanzapine			
Seroquel/Quetiapine			
Geodon/Ziprasidone			
Abilify/Aripiprazole			
Clozaril/Clozapine			
Revia/Naltrexone			
Campral/Acamprosate			
Eskalith/Lithobid/Lithium			
Depakote/Divalproex			
Depakene/Valproic acid			
Tegretol/Carbatrol/Carbamazepine			
Trileptal/Oxycarbazepine			
Lamictal/Lamotrigine			
Keppra/Levetiracetam			
Topamax/Topiramate			
Neurontin/Gabapentin			
Buspar/Buspirone			
Inderal/Propranolol			
Catapres/Clonidine			
Atarax/Vistaril/Hydroxyzine			
Ambien/Zolpidem			
Sonata/Zaleplon			
Desyrel/Trazodone			
Restoril/Temazepam			
Melatonin			
Valerian Root			
Xanax/Alprazolam			
Klonopin/Clonazepam			
Valium/Diazepam			
Tranxene/Clorazepate			
Librium/Chlordiazepoxide			
Ativan/Lorazepam			
Ritalin/Concerta/Methylphenidate			
Adderall/Mixed Amphetamine Salts			
Dexedrine/Dextroamphetamine			
Strattera/Atomoxetine			
Provigil/Modafinil			

Name	Took in Past	Particularly Helpful	Caused Side Effect (specify)
Intuniv/Guanfacine			
Exelon/Rivastigimine			
Reminyl/Galantamine			
Aricept/Donepezil			
Deplin/Folic Acid			
St. John's Wort			
SAM-e			
Omega 3 Fatty Acids			
B-Complex Vitamins			
Other herbals or natural remedies (List below)			

47. Suicide:

a. Have you ever thought about suicide? Yes ___ No___

If yes, when was the last time? ____

b. Have you ever attempted suicide? Yes ___ No ___

If yes, when and how? ____

c. Do you have thoughts about suicide currently? Yes ___ No ___

48. Recent Stresses and Life Events:

	Comments
Changed Residences	
Legal difficulties (ex. Multiple tickets)	
Owe money	
Traumatic Experiences	
Other (Please specify)	

49. Past History:

Check if during **childhood** you-

✓		Comments
	Were afraid to go to school	
	Had difficulty with reading, writing, or math	
	Were truant	
	Failed or repeated a grade	
	Wet the bed after age 5	
	Had tics	
	Had a stutter/stammer	
	Had nightmares, disturbed sleep, fear of dark	
	Ran away from home	
	Were cruel to animals	
	Frequently lied to family or others	
	Set fires	
	Moved frequently	
	Worried excessively about your appearance	

50. Are you currently, or have you ever been, married? Yes ___ No___

If so, when were you married?____________ Spouse's occupation____________________

When were you separated? _______________ Never_______

When were you divorced? ________________ Never _______

When were you remarried? ______________ Never _______
Comments: ____

51. Please list your hobbies and leisure activities: ____
____

52. Do you exercise regularly? Yes ___ No ___

If yes, how many times a week?
1. ____1x
2. ____ 2x
3. ____ 3x
4. ____ 4x or more

When you exercise, how long is each session?
1. ____ ≤ 15 min.
2. ____ 16-30 min.
3. ____ 31-45 min.
4. ____ > 45 min.

What type of exercise do you do?
______Jogging/Walking
______ Basketball
______ Home Aerobics
______ Tennis
______ Water Sports
______ Other ______________________________

53. Weight

What is your current weight in pounds? ________________
Has your weight increased or decreased by more than 10 pounds in the last year? Yes ___ No ___
If yes, please explain circumstances:
____
____

54. Sleep

What are your total average hours of sleep time per night? ______________________________________
Check if you:

	√
Have difficulty falling asleep	
Have difficulty staying asleep	
Wake early	
Are tired upon awakening	
Wake with a headache	
Jerk or have restless legs during sleep	
Snore	
Wake short of breath	
Have long pauses in breathing	

55. Family History

	Name	**Age** If deceased, age at death and cause of death	**List all psychiatric Illnesses** Ex. depression, bipolar disorder anxiety disorders, substance abuse, suicide attempts etc.	**Physical Illnesses** Ex. cancer, diabetes heart disease, rheumatism or autoimmune disorders alcoholism, Alzheimers (include age of onset)
Mother				
Father				
Brothers/ Sisters				
Spouse				
Children				
Grand- parents, Uncles, Aunts, (Etc.)				

56. Any other family history we should know about? Yes ___ No ___

If yes, please comment: ____

57. What is the attitude of those close to you about your illness?
______ Supportive ______ Non-supportive

FOR WOMEN ONLY (questions 58-65):

58. Have you ever been pregnant? Yes ___ No ___
Number of miscarriages _____ Number of abortions ______ Number of preemies ______
Number of term births ______ Birth weight of largest baby ______ Smallest baby ______
Did you develop toxemia (high blood pressure)? Yes ___ No ___
Have you had other problems with pregnancy? Yes ___ No ___
If yes, please comment: ____
____

59. Age at first period ______Date of last Pap Smear ______Date of last Mammogram______
Pap Smear: ___Normal ___Abnormal Mammogram:___Normal ___Abnormal

60. Have you ever used birth control pills? Yes ___ No ___ If yes, when? ______________

61. Are you taking the pill now? Yes ___ No ___

62. Did taking the pill agree with you? Yes ___ No ___ NA ___

63. Do you currently use contraception? Yes ___ No ___
If yes, what type of contraception do you use? __________________________________

64. Are you in menopause? Yes ___ No ___ If yes, age at last period ___________
Are you on hormone replacement therapy? Yes ___ No ___ If yes, when did you start?_____
Do you take: Estrogen?____ Ogen?____ Estrace?____ Premarin?____ Progesterone?____
Provera?____ Other (specify)______________________________________

65. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes ___ No ___ NA ___

66. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

GENERAL:	**Mild**	**Mod-erate**	**Severe**
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES, & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			
MUSCOLO-SKELETAL:	**Mild**	**Mod**	**Severe**
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			

	Mild	**Mod**	**Severe**
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness			
Fainting			
Fearfulness			
Irritability			
Light-headedness			
Numbness			
Other phobias			
Panic attacks			
Paranoia			
Seizures			
Tingling			
Tremor/trembling			
Visual hallucinations			

EATING:	Mild	Mod	Severe
Binge eating			
Bulimia			
Can’t gain weight			
Can’t lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			
Fissures			
Foods “repeat” (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			

DIGESTION, Cont’d:	Mild	Mod	Severe
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
SKIN PROBLEMS:			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete’s foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			
Eczema			
Herpes-genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			

SKIN PROBLEMS Cont'd	Mild	Mod	Severe
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			
SKIN, DRYNESS OF:			
Eyes			
Feet			
-any cracking?			
-any peeling?			
Hair			
-and unmanageable?			
Hands -any cracking?			
-any peeling?			
Mouth/throat			
Scalp			
-any dandruff?			
Skin in general			
LYMPH NODES:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			

NAILS:	Mild	Mod	Severe
Bitten			
Brittle			
Curve up			
Frayed			
Fungus-fingers			
Fungus-toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Fingernails			
Toenails			
White spots/lines			
RESPIRATORY:			
Bad breath			
Bad odor in nose			
Cough-dry			
Cough-productive			
Hay fever: Spring			
-Summer			
-Fall			
-Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			

CARDIO. Cont'd	**Mild**	**Mod**	**Severe**
Mitral valve prolapsed			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			
URINARY:			
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
FEMALE REPRODUCTIVE:			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			
Premenstrual:			

FEMALE REPRODUCTIVE Cont'd	**Mild**	**Mod**	**Severe**
Bloating			
Breast tenderness			
Carbohydrate cravings			
Chocolate cravings			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			