Calhoun CHIROPRACTIC Center

ACUPUNCTURE PATIENT INTAKE FORM

How did you find out about our office?_____

DATE: ___/___/___

NAME: _____ **DATE OF BIRTH:** ___/___/___ **AGE** _____

SOCIAL SECURITY #_____ **SEX: M F** **HEIGHT:**_____ **WEIGHT:** _____

ADDRESS: _____
(Street)

_____
(City) (State) (Zip)

PHONE: _____/_____/_____
(Home) (Work) (Cell)

E-MAIL: _____

EMERGENCY CONTACT: Name: _____

Address: _____

Phone: _____ Relationship: _____

PRIMARY CARE PHYSICIAN:

Do you have a primary care physician? yes ____ no ____ IF YES:

Name: _____

Phone: _____

WHAT IS THE MAIN REASON YOU ARE HERE TODAY?

_____

_____

_____

_____

HEALTH HISTORY

HAVE YOU EVER SMOKED? yes, currently ____ **OR:** yes, but I quit in (year) _____, **OR:** NO

DO YOU DRINK? (circle one) never rarely/socially weekly/socially daily

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? (circle one) Yes No

HAVE YOU EVER SUFFERED FROM SEIZURES? (circle one) Yes No

FEMALE PATIENTS: COULD YOU BE PREGNANT? (circle one) Yes No

Name:_____ Date: _____

MAJOR HEALTH CONCERNS, IN ORDER OF IMPORTANCE:

Complaint or Diagnosis	Since?	Possible Cause

LIST ANY HOSPITALIZATIONS, SURGERIES OR MAJOR INJURIES:

Hospitalizations/Surgeries	When?	Continuing Complications?
Major Injuries	**When?**	**Continuing Problems?**

FAMILY HISTORY:

- For each relation, please indicate if the person is living or deceased.
- If living, indicate current age; if deceased, list age at time of death.

Relationship	**Living?**	**Age**	**Major Health Concerns (or "good"), or Cause of Death**
Mother			
Father			
Mother's Mother			
Mother's Father			
Father's Mother			
Father's Father			
Siblings (list):			

Name: _____ Date: _____

LIST ALL MEDICATIONS AND SUPPLEMENTS YOU CURRENTLY TAKE:

Medication/Supplement	Since?	How often?	Reason for taking:

Please continue on back if you need more space to list medications. **More on back? (circle) Yes No**

Patient: Do not write below this line. Move on to the next page

HERBAL RECOMMENDATIONS

DATE	Any changes to meds above?	Note Change:	Recommending: FORMULA NAME/ Brand	DOSE

Name: _____ Date: _____

SYSTEMS REVIEW. CIRCLE ALL APPLICABLE. If you have a Western Diagnosis please write it in. Use left column only.
(Please do the best you can with this, even if some sections are irrelevant to today's visit.)

TEMPERATURE Run hot Run cold Spontaneous sweats (day or night) Feel hot or chilled at certain times of day or night Other:	**LEAVE THIS COLUMN BLANK.**
HEAD Headaches Migraines Dizziness Loss of balance Concussion Other:	
SENSES Hearing loss Ringing in the ears Nose bleeds Loss of sense of Taste Loss of sense of Smell Blurry Vision Floaters in vision Glaucoma Pain in eyes or ears Sores on tongue or inside mouth Other:	
SKIN Tingling Numbness Sensitivity Moles Psoriasis Easy bruising Sores/cuts take a long time to heal Eczema Spontaneous sweating Excessive sweating Other:	
RESPIRATORY / IMMUNOLOGIC Allergies Asthma Nasal drip Difficult breathing Shortness of breath Coughing Catch colds easily Frequent sinus problems Bronchitis HIV/AIDS Other:	
HEART / CHEST Chest pain Palpitations Tightness/Pressure in chest Heart attack High blood pressure Low blood pressure Varicose or Spider veins High cholesterol Swelling in legs or ankles Other:	

Name: _____ Date: _____

SYSTEMS REVIEW. CIRCLE ALL APPLICABLE. Use left column only.

GASTROINTESTINAL Gassiness Bloating Gallbladder issues Gall Stones Liver issues Food sensitivities Ulcers Heartburn GERD Pain or cramping in digestive tract Nausea Hepatitis Pancreatitis Pain or cramping after eating Fatigue after eating Other:	**LEAVE THIS COLUMN BLANK**
APPETITE AND THIRSTINESS My appetite is: average high low My thirst level is: average high low I prefer to drink beverages: warm cold room temperature I consume (circle all that apply): plain water soda coffee tea Gatorade flavored/vitamin water milk juice beer or wine Other: _____ Recent weight loss Recent weight gain Unhappy with weight Flavor cravings (salt, sugar, spicy): _____ Taste in mouth (metallic, sour, bitter) _____ Are you on a special diet (gluten-free, vegetarian, Mediterranean, etc.)? (write in type)	
BOWEL ELIMINATION How many bowel movements do you have a day: _____ If not daily, how often: _____ Diarrhea Constipation Loose Stool Undigested food in stool Excessively odorous stool Urgency Incontinence Blood in stool Mucous in stool Black stools Hard stools Crohn's Disease Celiac Disease Diverticulitis IBS Hemorrhoids Pain before bowel movement Pain or cramping after bowel movement Other:	

Name: _____ Date: _____

SYSTEMS REVIEW. CIRCLE ALL APPLICABLE. Use left column only.

URINARY ELIMINATION Difficult urination Painful urination Cloudy urine Burning Urgency Incontinence Kidney Stones Frequent UTI's/Cystitis What color is the urine (circle): Clear / pale yellow / yellow / dark yellow / almost orange Does the volume of urine eliminated seem like (circle one) **More** **less** **about the same** as what you consume in fluids? Do you get up from sleep at night to urinate? If yes, How many time?_____ Other:	
FEMALE REPRODUCTIVE Number of Pregnancies: _____ Number of Births: _____ Have you reached menopause? Yes No **If yes**, what year? _____ **If yes**: Do you have hot flashes or other symptoms? Yes No **If no**: Are your periods regular? Yes No How many days apart? ____ How many days do your periods last? _____ Do you have cramping or other menstrual discomfort? Yes No PMS: Yes No Clots: Yes No Breast Tenderness: Yes No Do you get frequent yeast/other infections/vaginal itching or burning? Yes No Are you trying to get pregnant? Yes No	**LEAVE THIS COLUMN BLANK**
MALE REPRODUCTIVE Dribbling urine Difficulty emptying bladder fully Low Sperm count) Burning with urination or ejaculation BPH (Benign Prostatic Hyperplasia Low Testosterone When was your last prostate exam? _____ Problems with or concern regarding erectile function? Yes No Other:	

Name: _____ Date: _____

SYSTEMS REVIEW. CIRCLE ALL APPLICABLE. Use left column only.

SLEEP Difficulty falling asleep Difficulty staying asleep Vivid dreams Waking up too early Not rested upon waking Fatigue Unable to sleep due to pain Unable to sleep because "can't turn brain off" Tossing and turning / can't get comfortable or relax enough to sleep How many hours of sleep are you getting a night: _____ Other:	
HORMONAL Hyperthyroid Hypothyroid Goiter Diabetes Metabolic syndrome Peri-menopause or menopause Other:	
MENTAL / NEUROLOGICAL Difficulty Concentrating Confusion Loss of coordination Memory loss: short term long term Tremors Stroke Difficult speech Disorientation Other:	
EMOTIONAL Even if you manage your emotions well, which of the following do you tend towards on a bad day? (circle all that apply) Anger Depression Sadness Self-doubt or loathing Anxiety Indecisiveness Go into Overdrive Numb / can't do anything Mind churns / can't stop thinking Feel fearful or despairing Other:	**LEAVE THIS COLUMN BLANK**

Name: _____ Date: _____

BRIEF LIFESTYLE REVIEW

Who do you live with? _____

Are you the primary caretaker for any family members or friends? _____

What kind of work do you do? _____

Are you on a specific diet? _____

How many meals do you eat a day? _____ Briefly describe an average:

Breakfast_____

Lunch_____

Dinner_____

Snacks _____

Based on your own definition, are you at a satisfactory weight for you? _____

Does your weight fluctuate? _____

How often do you exercise? _____

What type of exercise do you do? _____

Do you have a good social support system? _____

Do you have pets? _____

Do you consider yourself a spiritual person? _____

What do you do to relax? _____
(or do you have a hard time relaxing?)

How would you describe your energy level? _____

Are there times of the day when you are particularly low energy? _____

With 1 being almost none and 10 being "over the top" how stressed are you at this time of your life? _____

Name: _____ Date: _____

BODY REVIEW **Use this chart if you are here for aches / pains / old injuries / mobility / etc.**

Use the following codes to indicate for each body area the type of pain, whether it is constant or comes and goes and if the discomfort is due to injury. Use as many codes as necessary.

S = stiffness P = sharp pain D = dull pain
B = burning T = tingling N = numbness

Combine with the following to indicate frequency:

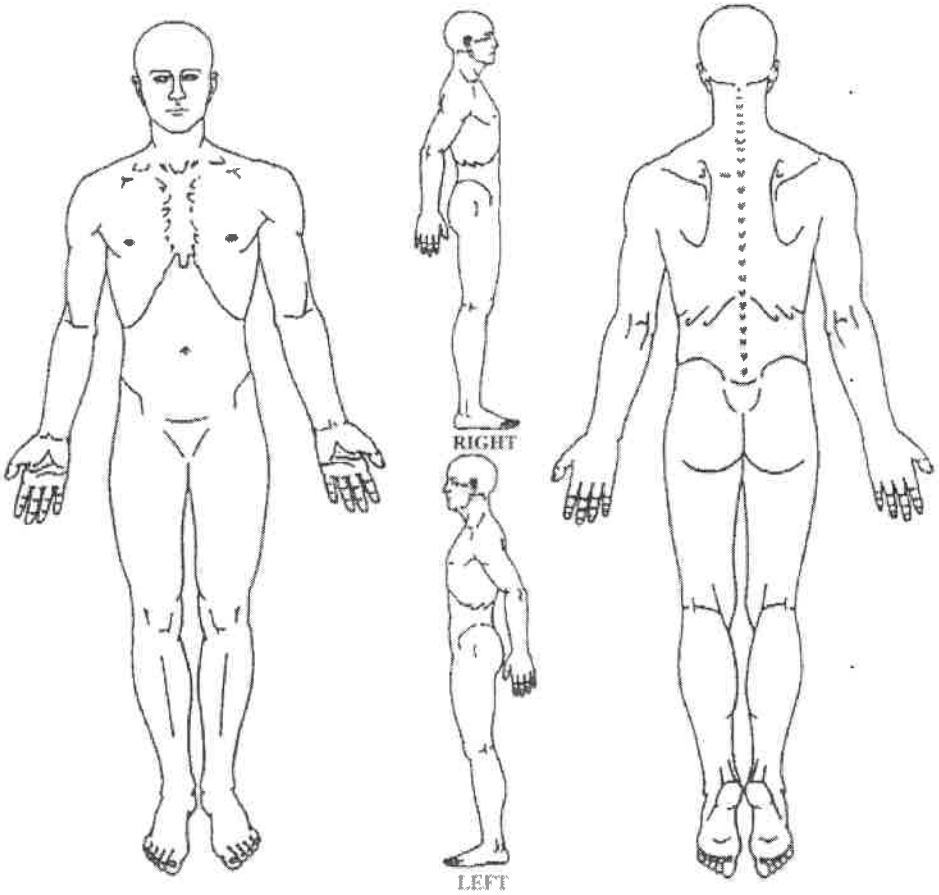
I = intermittent (comes and goes)
C = constant

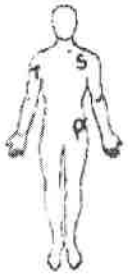
If due to an injury, add:

R = recent injury O = old injury

Have you been diagnosed with arthritis? (circle) No OA (Osteoarthritis) RA (Rheumatoid arthritis) Psoriatic Arthritis

Do you suffer from gout?





Example