

PERSONAL HISTORY

NAME: _____
STREET: _____
CITY: _____
ST: _____ ZIP: _____
BIRTHDATE: _____ AGE: _____ SEX M F
HOME PHONE: _____

MOBILE PHONE: _____
PAGER: _____
E-MAIL: _____
WEBSITE: _____
NAME OF SPOUSE: _____
EMERGENCY CONTACT & PH #: _____

TYPE OF WORK: _____
EMPLOYER: _____
BUSINESS PHONE: _____

RELATIONSHIP: _____

**REFERRED TO OFFICE
BY:** _____

CHECK ONE: MARRIED SINGLE WIDOWED DIVORCED SEPARATED
OF CHILDREN _____

WHO IS RESPONSIBLE FOR YOUR BILL: SELF SPOUSE OTHER

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT: _____

OTHER DOCTORS SEEN FOR THIS CONDITION: YES NO WHO? _____

TYPE OF TREATMENT _____
RESULTS _____

WHEN DID THE CONDITION BEGIN? _____ NEW CONDITION YES NO
IS CONDITION JOB RELATED AUTO RELATED HOME INJURY FALL
OTHER: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

OTHER CONDITIONS WHICH YOU SUFFER FROM: _____

PAST HEALTH HISTORY

MAJOR SURGERIES: APPENDECTOMY TONSILLECTOMY GALLBLADDER
HERNIA BACK SURGERY BROKEN BONES
OTHER _____

MAJOR ACCIDENTS OR FALLS _____

PREVIOUS ACUPUNCTURE CARE NONE DOCTOR'S NAME & APPROXIMATE DATE OF
LAST VISIT _____

Head, Eyes, Ears, Nose and Throat

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Poor Hearing |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Excessive Phlegm | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Grind Teeth | <input type="checkbox"/> Color of Phlegm _____ | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Red Eyes | <input type="checkbox"/> TMJ | | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Recurrent Sore Throat | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Spots in Eyes | <input type="checkbox"/> Gum Problems | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Other Head/Neck Problems _____ |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Sores on Lips or Tongue | <input type="checkbox"/> Lumps in Throat | |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Enlarged Thyroid | |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Excessive Saliva | <input type="checkbox"/> Nose Bleeds | |
| <input type="checkbox"/> Glaucoma | | <input type="checkbox"/> Ringing in Ears | |

Respiratory

- | | | | |
|---|--|------------------------|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chest | Wet or Dry? _____ | |
| <input type="checkbox"/> Difficulty Breathing when lying down | <input type="checkbox"/> Asthma/Wheezing | Thick or Thin? _____ | <input type="checkbox"/> Coughing Blood _____ |
| | <input type="checkbox"/> Cough | Color of Phlegm: _____ | |

Cardiovascular

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Palpitations | |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Phlebitis | |

Gastrointestinal

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Intestinal Pain or Cramping | <input type="checkbox"/> Anal Fissures |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Itchy Anus | Bowel Movements |
| <input type="checkbox"/> Acid Regurgitation | <input type="checkbox"/> Constipation | <input type="checkbox"/> Burning Anus | Frequency: _____ |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Laxative Use | <input type="checkbox"/> Rectal Pain | Color: _____ |
| <input type="checkbox"/> Hiccups | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Hemorrhoids | Odor: _____ |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Mucous in Stools | | Texture: _____ |

Musculoskeletal

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Neck/Shoulder Pain | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Limited Range of Motion | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Limited Use | |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Rib Pain | | |

Skin and Hair

- | | | | |
|-------------------------------------|------------------------------------|---|-------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in Hair/Skin Texture | _____ |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Fungal Infection | _____ |
| <input type="checkbox"/> Ulceration | <input type="checkbox"/> Itching | <input type="checkbox"/> Other Hair/Skin Problem: _____ | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair Loss | | |
| <input type="checkbox"/> Psoriasis | | | |

Neuropsychological

- | | | | |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression | <input type="checkbox"/> Abuse Survivor | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Considered/Attempted Suicide | |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Irritability | <input type="checkbox"/> Seeing a Therapist | |
| <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Easily Stressed | | |

List medications you are currently taking

Meds	Strength	How many per day?	For how long?

List substances or medications you are allergic to: _____

List significant family history: _____

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, there are many conditions that respond favorably when treatment is given that increased you body's ability to function correctly. This office specializes in such treatment and if you wish, an individualized program will be suggested.

Check any of the following conditions you currently have or have had in the past. Please also check if any of the following are a significant part of your medical history.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disorders | _____ |

Your Diet

- Appetite Hi Lo Artificial Sweetener Thirst for Water: _____
 Coffee Sugar # of Glasses per Day _____
 Soft Drinks Salty Food

Vitamins taken in the past two months: _____

Your Lifestyle

- | | | | |
|------------------------------------|---|---|------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drugs | <input type="checkbox"/> Regular Exercise | Type: _____ |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Stress | Type: _____ | Frequency: _____ |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Occupational Hazards | Frequency: _____ | |

General Symptoms

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Heavy Appetite | <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Strongly like Cold Drinks | <input type="checkbox"/> Heavy Sleep | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Vertigo or Dizziness |
| <input type="checkbox"/> Strongly like Hot Drinks | <input type="checkbox"/> Dream Disturbed Sleep | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Bleed or Bruise Easily |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever | <input type="checkbox"/> Peculiar Taste (describe): _____ |
| <input type="checkbox"/> Recent Weight Gain | <input type="checkbox"/> Lack of Strength | <input type="checkbox"/> Chills | _____ |
| | <input type="checkbox"/> Bodily Heaviness | <input type="checkbox"/> Night Sweats | |
| | | <input type="checkbox"/> Sweats Easily | |

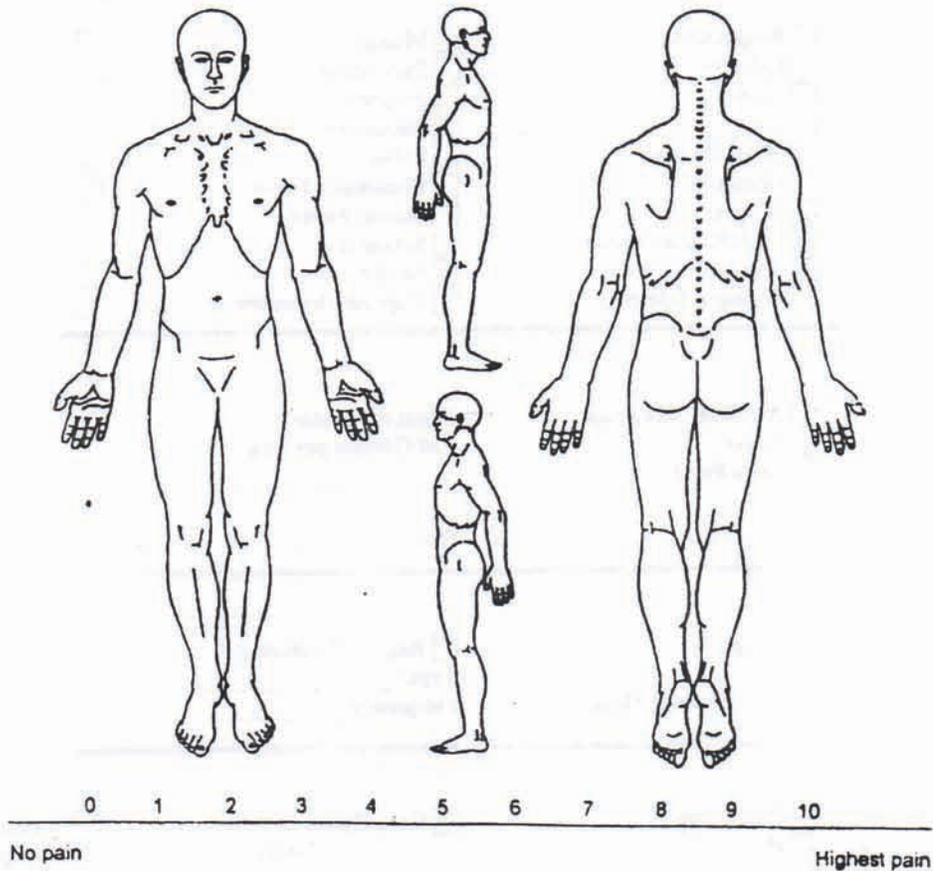
Genitourinary

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Incomplete Urination | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Impotence | |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Wake to Urinate | <input type="checkbox"/> Premature Ejaculation | |
| <input type="checkbox"/> Incontinent | <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Nocturnal Emission | |

Gynecological

- | | | | |
|-------------------------|--|--|---------------------------------------|
| Age Menses Began: _____ | Date Last Period Began: _____ | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> PMS |
| Cycle Length: _____ | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Breast Lumps |
| Flow Duration: _____ | <input type="checkbox"/> Painful Periods | Color: _____ | # of Pregnancies: _____ |
| | <input type="checkbox"/> Vaginal Odor | Date of Lat PAP: _____ | # of Live Births: _____ |
| | | <input type="checkbox"/> Clots | # of Premature Births: _____ |
| | | | Age of Menopause: _____ |

PLEASE INDICATE THE LOCATION AND PAIN LEVEL YOU HAVE RIGHT NOW:



PATIENT/ GUARDIAN SIGNATURE _____ DATE: _____