# Patient Information

Date____________________________________________________________________

Patient Name ___________________________________________________________

What do you prefer to be called?_______________________________________

Address ________________________________________________________________

City________________________ State________ Zip Code__________________

Gender M F Birth date ______________________ Age______________

Patient Employer/School_________________________________________________

Occupation _____________________________________________________________

Relationship Status: Married _____ Single _____ Divorced _____

Domestic Partnership _____ Widowed _____ Other ___________________

Primary Care Physician _________________________________________________

Who may we thank for referring you? _________________________________

# Contacts

Home Phone (____)______________________________

Cell Phone (____)______________________________

Work Phone (____)______________________________

Best time and place to reach you:

AM ______ NOON______ PM _______

Work _____ Home ______ Cell _______

**E-mail** ____________________________________________

**In Case of Emergency, contact:**

Name___________________________________________

Relationship___________________________________

Phone number(s)________________________________

# Patient Condition/Accident Information

Reason for visit ____________________________________________________________

When did your symptoms appear? ______________________________________________

Is this condition due to an accident? Y N Date of accident ____________________

What type of accident? Auto ______ Work ______ Home ______ Other _______________

Is this condition getting progressively worse? Y_____ N______ Unknown______

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _______

Type of pain: Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting ___

Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other ___________

How often do you have this pain? ___________________________________________

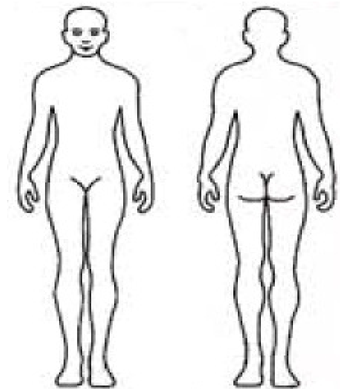
Is it constant or does it come and go? _____________________________________

Does it interfere with your: Work ______ Sleep ______ Daily Routine ______ Recreation ______

Activities or movements that are painful to perform:

Sitting _______ Standing _______ Walking _______ Bending _______ Lying Down _______

Please mark an X on the picture where you continue to have pain, numbness, or tingling.



# Insurance Information

Who is responsible for this account? _________________________

Relationship to Patient ________________________________

Insurance Co. __________________________________________

Group # ________________________________________________

Is patient covered by additional insurance? Y N

Subscriber's Name ______________________________________

Birth date _____________________________________________

Relationship to patient ________________________________

Insurance Co ___________________________________________

Group # ________________________________________________

**Assignment and Release:**

I certify that I, and /or my dependent(s) have insurance coverage with _______________ and assign directly to Dr. _______________ all insured benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above- named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

**Signature of Patient, guardian, or personal representative**:

________________________________ Printed Name_____________________

Date_______________ Relationship to patient ___________________________

# Medical History

**What treatment have you already received for your condition?**

Medications ____ Surgery ____ Physical Therapy ____ Chiropractic ____ Acupuncture ____ None _____ Other ___________________

**Date of last :** Physical Exam __________ Spinal Exam __________ Spinal X-ray __________ Chest X-ray __________ Blood Test ___________

MRI, CT Scan, Bone Scan __________

**Please CIRCLE to indicate if you currently HAVE & underline if you have HAD any of the following:**

| | | | | |
|---|---|---|---|---|
| AIDS/HIV | Chemical Dependency | Herpes | Joint Problems | Rheumatoid Arthritis |
| Alcoholism | Diabetes | High Cholesterol | Headaches | Stroke |
| Anemia | Fibromyalgia | Kidney Disease | Sciatica | Hyperthyroidism |
| Appendicitis | Fractures | Liver Disease | Osteoporosis | Hypothyroidism |
| Arthritis | Heart Disease | Migraines | Pacemaker | Skin Condition |
| Asthma | Hepatitis | Mononucleosis | Pinched Nerve | Circulatory Disorder |
| Bleeding Disorders | Hernia | Multiple Sclerosis | Prostate Problem | Tumors, Growths |
| Cancer | Herniated Disk | Numb hands/feet | Prosthesis | Other __________________ |

**Please CIRCLE to indicate if you currently HAVE & underline if you have HAD any of the following:**

| | | | | |
|---|---|---|---|---|
| Allergy Shots | Chicken Pox | Gout | Polio | Tuberculosis |
| Anorexia | Emphysema | Measles | Psychiatric Care | Typhoid Fever |
| Breast Lump | Epilepsy | Miscarriage | Rheumatic Fever | Ulcers |
| Bronchitis | Glaucoma | Mumps | Scarlet Fever | Vaginal Infections |
| Bulimia | Goiter | Parkinson's Disease | Suicide Attempt | Venereal Disease |
| Cataracts | Gonorrhea | Pneumonia | Tonsillitis | Whooping Cough |
| Alzheimer's | High Blood Pressure | Cystic Fibrosis | Emotional Disorder | Hemophilia |
| Crohn's Disease | Irritable Bowel (IBS) | Lupus (SLE) | Seizures | Ulcerative Colitis |
| Other ____________________ | Other______________________ | | | |

# Medications/Supplements

| MEDICATION | DOSAGE | REASON | HOW LONG | PRESCRIBED BY | LAST EVALUATION |
|---|---|---|---|---|---|
| | | | | | |
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Allergies:_______________________________________________

# Health History

**Please indicate your use/intake of the following:**

| | | | Amount (per day) |
|---|---|---|---|
| Water intake | Y | N | _________ |
| Sodas | Y | N | _________ |
| Recreational Drugs | Y | N | ________ |
| Alcohol | Y | N | _________ |
| Coffee/Black Tea | Y | N | _________ |
| Tobacco | Y | N | _________ |

**Injuries/Surgeries you have had:**

| | Description | Date |
|---|---|---|
| Falls | ___________________________________ | ___________ |
| Head Injuries | ___________________________________ | ___________ |
| Broken Bones | ___________________________________ | ___________ |
| Dislocations | ___________________________________ | ___________ |
| Surgeries | ___________________________________ | ___________ |
| Car Accidents | ___________________________________ | ___________ |

**Exercise:** ____ None ____ 1X/MONTH ____ 1X/WK ____ 2-3X/WK ____ 4X +/WK

**Work Activity:** ____ Sitting ____ Standing ____ Light Labor ____ Heavy Labor ____ Other ________________

**Stress Level:** ____ Low ____ Moderate ____ High Sources of Stress __________________________________

What activities, if any, do you participate in to reduce your stress levels? ________________________________________________________

Are you pregnant? Y N Due Date________________

Have you ever had a lapse of memory? Y N When? _________________________________________________________________

Were you ever knocked unconscious? Y N When? _________________________________________________________________

How many hours per day do you use a computer? ______________________________________________________________________________

How many hours of quality sleep do you get each night? ________________________________________________________________________

# Symptom Survey

**Please CIRCLE to indicate if you currently HAVE & underline if you have HAD any of the following:**

**If current, indicate how often you experience that symptom.**

| | | |
|---|---|---|
| Lack of appetite | Excessive talking | Eye problems |
| Excessive appetite | Inappropriate laughter | Jaundice |
| Loose stool | Chest pain | Easily angered/irritated |
| Blood in stools | Abdominal pain | Difficulty making decisions |
| Diarrhea | Sciatic pain | Soft or brittle nails |
| Indigestion | Coughing | Muscle spasms/twitching |
| Vomiting/Nausea | Shortness of breath | Dizziness/vertigo |
| Belching/Burping | Poor sense of smell | Low back pain |
| Heartburn/Acid reflux | Sinus/nasal problems | Knee problems |
| Bloating | Tightness in the chest | Poor hearing |
| Food retained in stomach | Skin rashes | Ringing in ears |
| Depression | Dry skin | Hair loss |
| Fatigue | Severe acne | Kidney stones |
| Obsessive tendencies | Pain or coldness in genitals | Urinary difficulty |
| Insomnia | Hemorrhoids | Edema |
| Heart palpitations | Black/tarry stool | Other __________________ |
| Cold hands and feet | Diverticulitis | Other __________________ |
| Nightmares | Gallstones | Other __________________ |
| Anxiety | Difficulty digesting oily food | |
| Mentally restless | Light colored stool | |

# ACUPUNCTURE ONLY

Have you received acupuncture or Chinese herbal therapy before? Y N If so, how long ago? ________________________________________

With whom? ________________________________________ For what reason? ______________________________________________________________

**Please answer the following questions:**

Are you easily bruised? Y N

Do you tend to catch colds or the flu easily? Y N

Are you intolerant to weather changes? Y N

Have you experienced a sudden, significant weight gain or loss? Y N ...if yes, ____ gain ____ loss

*How do you feel about the following areas of your life?*

| | Great | Good | Fair | Poor | Bad | Comments |
|---|---|---|---|---|---|---|
| Significant other | | | | | | |
| Family | | | | | | |
| Diet | | | | | | |
| Sex | | | | | | |
| Self | | | | | | |
| Work | | | | | | |
| Spirituality | | | | | | |

What are the main health concerns for which you are seeking treatment? ______________________________________________________________

What other forms of treatment have you used? ________________________________________________________________________________________

List any other health concerns you currently have: ____________________________________________________________________________________

## Reproductive History

Sexually Transmitted Diseases: ___ Gonorrhea ___ Syphilis ___AIDS ___ HPV ___ Chlamydia ___ Herpes Dates: _____________

Color of urine: _______________________ ______Clear ______ Murky _____ Odor

***Women:***

**Menses:**
Age of 1st period (menarche) _____
Age of final period (Menopause)_____
# of days between periods _____
# of days of flow ___
Color of flow ____
Clots? Y N Color: _____

**Pregnancies:**
# of pregnancies ______
# of live births ______
# of multiple births _______
# of miscarriages ______
# of abortions _______

**Exams/Results:**
Date of last GYN exam: _________________________
Date of last PAP smear: ________________________
Date of last mammogram: _______________________
Date of last bone density exam: ________________
Results: ________________________________________

Have you been diagnosed with: ____ Fibroids ____ Fibrocystic Breasts ____ Endometriosis ____ Ovarian Cysts ____ PID
____ Breast Cancer ____ Ovarian Cancer ____ Interstitial Cystitis ____ Frequent UTI's ____ Other ________________

Location of Menstrual Discomfort: _____ Lower abdomen _____ Lower back _____ Thighs

*Nature of Discomfort:* ____ Cramping ____ Stabbing ____ Burning _____ Aching _____ Dull _____ Bloating
____ Consistent _____ Intermittent ____ Bearing-down sensation

*Timing of Discomfort:* ____ Before Menses ____ During Menses ____ After Menses

*Menstrual & Premenopausal Symptoms*: ____ Discharge _____ Nausea ____ Swollen Breasts ____ Excessive appetite ____ Headache
_____ Increased libido ____ Urinary Incontinence ____ Vaginal dryness ____ Constipation ____ Mood swings ____ Diarrhea
_____ Decreased libido _____ Poor appetite ____ Insomnia _____ Night sweats ____ Hot flashes ____ Other _____________

***Men:***
*Reproductive and prostate related symptoms*: ____ Delayed Stream ____ Dribbling ____ Urinary Incontinence ____ Retention of urine
____ Rectal dysfunction ____ Increased libido ____ Decreased libido ____ Premature ejaculation ____ Impotence
____ Groin pain _____ Testicular pain _____ Penile discharge ____ Back pain

Date of last prostate exam: ______________ PSA results: _______________ Prostate exam results: _____________________________________

Have you been diagnosed with: ___ Inguinal Hernia ____ Erectile Dysfunction ____ Low sperm count ____ Prostate Cancer
____ Testicular Cancer _____ Un-descended Testis _____ Other _________________________________