Acupuncture Intake and History Forms

Date: _____

Patient Name: _____ Cell Phone: _____ Carrier: _____

Address:_____City:_____ State:_____ Zip:_____

Date of Birth: _____ Age:_____ Home Phone:_____ Preferred Contact: Home or Cell

Email:_____ How were you referred to the office?_____

Name and Phone Number of Primary Care Physician: _____

Emergency Contact: _____Phone:_____

Have you had acupuncture before? YES NO If so, Where and what was outcome? _____

_____

Main Complaint

Please list your complaints or health goals with Acupuncture:

_____

_____

_____

When and how did the complaint begin?_____

_____

On a scale of 0 to 10, how severe are your symptoms? (0 being none, 10 being very severe) _____

What makes it worse? _____

What makes it better? _____

What diagnosis have you been given for these problems? _____

What other treatments have you tried and what were the outcomes? _____

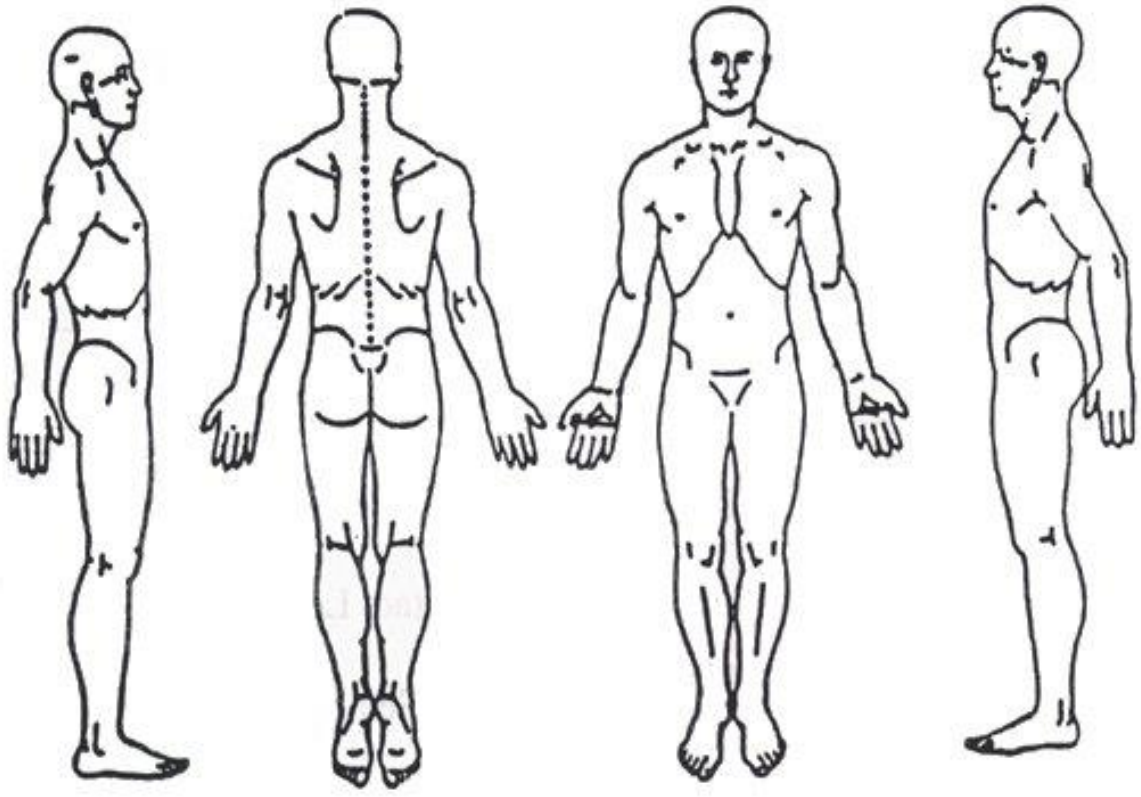
_____

Personal History

Illnesses/Current Health Issues within the last year	
Major Surgeries	

Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.)	
Do have a history of current or past infectious disease? Please describe	
Medicines (please list all medications, herbs, vitamins and over the counter drugs)	
Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to)	

Please describe pain and place on diagram below:



Please place a check below if you have had symptoms within the last six (6) months:

General

- ❑ Poor Appetite
- ❑ Hearing Loss
- ❑ Easy to Bleed or Bruise
- ❑ Strong Thirst
- ❑ Puffiness or Swelling
- ❑ Night Sweats
- ❑ Changes in Appetite
- ❑ Weakness
- ❑ Fevers
- ❑ Sweat Easily
- ❑ Poor Sleep
- ❑ Poor Balance
- ❑ Cravings
- ❑ Other:
- ❑ Sudden Energy Drops
- ❑ Chills
- ❑ Fatigue
- ❑ Tremors
- ❑ Weight Loss
- ❑ Weight Gain

Please place a check below if you have had symptoms within the last six (6) months:

Skin & Hair

- ❑ Rashes
- ❑ Skin Ulcers
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Hair Loss
- ❑ Recent Moles

Head, Eyes, Ears, Nose, and Throat

- ❑ Dizziness
- ❑ Cataracts
- ❑ Taste/Smell Problems
- ❑ Eye Strain/Pain
- ❑ Nose Bleeds
- ❑ Migraines
- ❑ Recurrent Sore Throat
- ❑ Toothache
- ❑ Ear Ringing
- ❑ Headaches
- ❑ Night Blindness
- ❑ Facial Pain
- ❑ Ear Aches
- ❑ Lip or Tongue Sores
- ❑ Blurry Vision
- ❑ Sinus Problems
- ❑ Concussions
- ❑ Poor Hearing
- ❑ TMJ Pain
- ❑ Spots in Front of Eyes
- ❑ Floaters

Cardiovascular

- ❑ High Blood Pressure
- ❑ Cold Hands or Feet
- ❑ Swelling of Hands
- ❑ Phlebitis
- ❑ Low Blood Pressure
- ❑ Blood Clots
- ❑ Swelling of Feet
- ❑ Fainting
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Chest Pain
- ❑ Lightheadedness

Respiratory

- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitis
- ❑ Coughing Up Blood
- ❑ Painful Breathing
- ❑ Difficulty Breathing
- ❑ Pneumonia
- ❑ Easily Winded

Gastro-Intestinal

- ❑ Nausea
- ❑ Bad Breath
- ❑ Chronic Laxative Use
- ❑ Indigestion
- ❑ Blood in Stools
- ❑ Constipation
- ❑ Ulcers
- ❑ Vomiting
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Intestinal Gas
- ❑ Belching

Urology

- ❑ Painful Urination
- ❑ Decrease in Urine Flow
- ❑ Cloudy Urine
- ❑ Pain in Groin Area
- ❑ Urgency to Urinate
- ❑ Frequent Urination
- ❑ Kidney Stones
- ❑ Sexually Transmitted Disease
- ❑ Unable to Hold Urine
- ❑ Blood in Urine
- ❑ Frequent Night Urination

Neuro-Psychological

- ❑ Seizures
- ❑ Twitches
- ❑ Irritability
- ❑ Poor Memory
- ❑ Tremors
- ❑ Areas of Numbness
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Anxiety
- ❑ Concussion
- ❑ Depression
- ❑ Stress
- ❑ Mood Swings

Please place a check below if you have had symptoms within the last six (6) months:

Gynecology

_____ Age of Menses	❑ Irregular Periods	❑ Clots
_____ Duration of Menses	❑ Painful Periods	❑ PMS
_____ Date of Last Menses	❑ Breast Lumps	❑ Menopausal
_____ # of Pregnancies	❑ Spotting	❑ Yeast Infections
_____ # of Births	❑ Vaginal Discharge	❑ Fertility Problems

Musculo-Skeletal

❑ Arthritis	❑ Muscle Weakness	❑ Muscle Cramping
❑ Muscle Spasms	❑ Scoliosis	❑ Weak Joints
❑ Pain with Weather Changes	❑ Pain with Activity	❑ Pain After Waking

Do you currently have an exercise regimen? _____ If so, please describe: _____

_____

Do you drink coffee? _____ How much? _____

Current tobacco use? _____ How much? _____

Do you drink alcohol? _____ How often? _____

Are you under regular stress? _____ If so, how often and how are your currently managing it? _____

_____

I certify the information provided is accurate to the best of my knowledge:

Signature of Patient _____ Date: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone (other than the parties mentioned above) that you do want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____