LiveWell Chiropractic & Wellness

ACUPUNCTURE PATIENT INTAKE

PATIENT INFORMATION

Date _____
Patient_____
Address_____
City_____State_____Zip_____
Sex: ◊ M ◊ F Age: _____DOB:_____
◊Single ◊Married ◊Divorced ◊Widowed ◊Separated
Patient SS# _____-_____-_____
Occupation: _____
Employer: _____
Spouse's Name: _____
Birthdate: _____ SS# _____-_____-_____
Occupation: _____
Spouse's Employer: _____
Whom may we thank for referring you? _____
_____
Name of Medical Doctor:
_____
Facility_____Ph._____

PHONE NUMBERS

Home _____Cell_____
Email_____
Best time/place to contact you ◊AM ◊PM ◊Home ◊Cell
In case of emergency, contact:
Name_____Phone_____

Acupuncture has been explained to me as a treatment consisting of inserting needles through the skin at specific points on the surface of the body, (small amount of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Massage, acupressure, acupuncture, reflexology, preventative or corrective exercise and nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. It is recommended that you CONSULT YOUR PHYSICIAN for any serious conditions and get at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications can result from acupuncture treatment. Among these possible complications are areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax and aggravation to present symptoms. Client further understands and agrees to hold harmless, to indemnify and protect against court action the therapist, management and owners of this clinic, in the unlikely event of accidental injury on these premises.

Signed_____ Date_____

FAMILY MEDICAL HISTORY

*Place **X** if applies to you, or indicate; **F**ather, **M**other, **B**rother, **S**ister, **G**randparent

Diabetes_____ Stroke_____ Hypertension_____ Low Blood Pressure_____ Heart Disease_____ Cancer_____
Psoriasis_____ Lupus_____ TB/Emphysema_____ Kidney Disease_____ Liver Disease_____
Headache/Migraine_____ Arthritis_____ Osteoarthritis_____ Rheumatoid Arthritis_____ Spinal Problems_____
Asthma_____ IBS_____ M.S._____ GURD_____ Gout_____ Stomach Ulcers_____ Eye Disease_____
Acid Reflux_____ Mental Illness_____ Epilepsy/Seizures_____ Allergies/Sinus_____ Bleeding Disorders_____
Thyroid Dis._____ Alcoholism_____ Drug Addiction_____ Miscarriage_____

Is there a possibility you are pregnant? ◊ YES ◊ NO Due Date _____

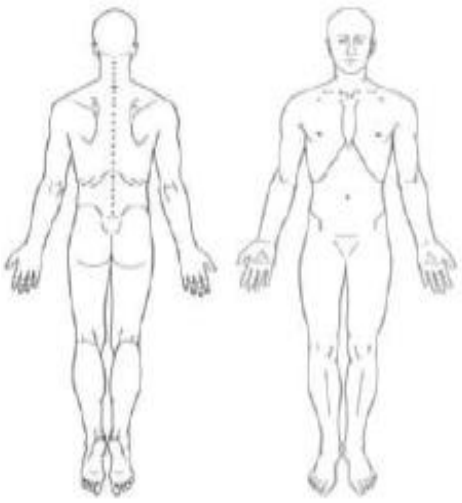
MEDICAL HISTORY (Surgeries, Illnesses, Accidents)

Year:	Description	Outcome:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS, VITAMINS, HERBS

Medication	Reason	Year Started

PRIMARY COMPLAINT



Reason for visit _____
When did symptoms appear? _____
Is condition getting progressively worse? ◊ YES ◊NO ◊Unknown
Rate the severity of your symptom on a scale of 1 (least) to 10 (severe) _____
Please mark on picture at right to show where your discomfort is.
Type of pain: ◊Sharp ◊Dull ◊Throbbing ◊Numbness ◊Other_____
Time of day it is worse ◊AM ◊PM What % of day in pain _____
Does it interfere with ◊Work ◊Sleep ◊Recreation ◊Daily Routine
Is there anything you do that relieves the symptom?
_____
What makes the symptoms worse? _____
_____
Have you ever had this symptom or condition before? ◊ YES ◊NO
Have you ever received treatment? ◊ YES ◊NO
If yes, when? _____By whom? _____
What was the diagnosis? _____

CONTAGIOUS DISEASE (Check if you have ever had or currently have one of the following):
_____Hepatitis _____AIDS _____HIV + _____Venereal Disease _____Herpes _____Other
ALLERGIES _____

_____

LIFESTYLE

HABITS:

Alcohol: _____ None _____ Drinks/week
Tobacco: _____ None _____ Cigarettes / Packs (circle one) per day.
Caffeine: _____ None _____ Cups of Coffee / Tea / 12 oz. Sodas (circle one) per day.
Sugar: _____ Salt: _____ Recreational Drugs: _____

Stress Scale: 1 2 3 4 5 6 7 8 9 10

EXERCISE: ____Never _____Little _____Moderate _____Heavy Type of exercise? _____
_____

EMOTIONS:

____Happy	____Worry	____Easily Irritable	____Difficulty making decisions
____Angry	____Sad	____Cry easily	____Hurry to do things
____Fearful	____Anxiety	____Over think or worry	____History of Depression

DIET (please mark with x all foods eaten and cross off foods you avoid)

___Beef	___Eggs	___Cheese	___Grains	___Tofu
___Pork	___Bread	___Margarine	___Fried Food	___Yogurt
___Poultry	___Milk	___Ice Cream	___Sweet	___Health Bars
___Fish	___Butter	___Vegetables	___Salads	___Hot Spicy

Other Cravings? _____
Do you eat three meals per day? Yes No
Do you eat at regular hours? Yes No what times do you eat? _____
Appetite: ___Up and Down ___Poor ___Constant hunger ___Loss of taste ___Normal

WEIGHT: __Underweight ___Overweight ___Recent gain ___Recent loss ___Normal

ENERGY:

___Up and Down	___Low	___Excess
___Tired in afternoon	___Wake up tired	
___Low after eating	___Normal	

SLEEP:

____Difficulty falling asleep	____Lots of dreams	____Tired upon rising
_____Awake easily	____Nightmares	_____Sleep too much
_____Difficulty going back to sleep	____Restless	____Normal

How many hours of sleep do you prefer? _____ How many do you actually get?_____

General Symptoms

BODY TEMPERATURE:

____Warm natured
____Cold natured
____Cold hands and feet
____Flushed face
____Warm palms/Warm soles
____Feel warm late afternoon or night

PERSPIRATION:

_____Very little
_____Profuse
_____Without exertion
____Easily
____Palms
____Feet
____Night sweats
____Bad smell
____Normal

DIGESTION AND BOWELS:

____Indigestion
____Heartburn
____Belch/burp
____Gas
____Bitter taste in mouth
____Ulcers
____Nervous Stomach
____Nausea/Vomiting
____Stomach noises
____Bad breathe
____Gallstones
____Normal
____Bloating
____Full feel or distention
____Abdominal pain or cramps
____Difficulties with fatty/oily food
____Weight problems

BOWELS:

How frequent do you have a bowel movement? _____times daily

____Loose stool
____Diarrhea
____Formed stool
____Hard Stool
____Colon problems
____Intestinal worms/parasites
____Blood in stool
____Small amount of stool
____Black stool
____Mucous in stool
____Burning anus
____Pain or cramps
____Undigested food in stool
____Stool with very bad smell
____Constipation: _____for how long?
____Anus itch
____Hemorrhoids
____Use of laxative

URINATION:

____Frequent
____Burning
____Bladder infections

HISTORY OF:

____Nighttime
____Profuse
____Cloudy
____Not normal color
____Dribble urine during urination
____Blood
____Pus
____Scanty
____Genital pain
____Incontinence
____Strong smell
____Painful
____Dribble urine
____Normal
____Kidney Stones
____Kidney infections
____Urgency
____Prostate problems

THIRST:

____Less than normal ____Prefer cold drinks ____Prefer hot/warm drinks ____Excessive thirst

HEADACHES - DIZZINESS:

____Headaches	____Vertigo	____Bend down/up dizziness
____Dizziness	____Motion sickness	____Poor balance
____Faint easily	____Migraines	____Poor memory
____Normal		

SKIN:

____Dry	____Hives	____Clammy
____Oily	____Bruise easily	____Body odor
____Rashes	____Cuts heal slowly	____Boils
____Itching	____Yellow skin	____Eczema
____Normal		

HAIR:

____Dry	____Dandruff	____Early grey
____Oily	____Falling out	____Normal

EYES:

____Wear glasses/contacts	____Cataracts	____Red
____Spots or lines in vision	____Glaucoma	____Dry
____Poor night vision	____Pain	____Itch
____Sensitive to light	____Normal	

EARS:

____Poor hearing	____Ringing (high pitched)	____Discharges
____Ear ache	____Ringing (low pitched)	____Normal

NOSE:

____Current stuffy nose	____Hay fever/Allergies	____Sneeze a lot
____Mucous	____Bleeding	____Loss of smell
____Sinusitis	____Rhinitis	____Normal

Date or season of last cold or flu_____

MOUTH AND THROAT:

____Dry ____Gum problems ____TMJ/Grind

____Hoarseness ____Sores in mouth/on tongue ____Thyroid problem

____Swollen glands ____Feel lump in throat ____Teeth problem

RESPIRATORY:

____Shortness of breath ____Difficulty inhaling ____Cough with blood

____Chest pain ____Difficulty exhaling ____Dry cough

____Asthma ____Difficulty breathing when lying down ____Cough with

____Bronchitis ____Tightness in chest phlegm

____Normal ____Sigh a lot

CARDIOVASCULAR – CIRCULATION:

____Diagnosed heart problems ____Palpitations

____Low blood pressure ____High cholesterol

____High blood pressure ____Varicose veins

____Murmur ____Bruise easily

____Slow heart beat ____Numbness of extremities

____Irregular heart beat ____History of anemia

____Normal

FOR FEMALES ONLY:

Are you pregnant? ____Yes ____No ____Maybe

If yes, what is the approximate date of conception? _____

Do you have regular Pap test? ____Yes ____No How regular? _____

Do you do regular breast exams? ____Yes ____No How regular? _____

GYNECOLOGICAL HISTORY AND OPERATIONS:

___Ovaries ____Breast ____Uterus ____Vagina ____Fallopian tubes ____Other

What method of birth control do you now use? _____

What method of birth control have you used in the past? _____

PREGNANCIES:

Total Number: _____ Number of children: _____

Pregnancy or Childbirth complications: _____

_____

MENSTRUAL CYCLE:

Age started: _____ Age stopped: _____ How many days between periods? _____

How many days of flow? _____ Describe flow: _____

Does it begin as bright red or as a dark brownish red? _____

What is the coloring at the end? _____

PMS SYMPTOMS

____Irregular	____Clotting	____Backache
____Water retention	____Dark color flow	____Sigh a lot
____Light color flow	____Scanty flow	____Lump in throat feeling
____Abdominal bloating	____Heavy flow	____Constipation and/or diarrhea
____Painful or tender breast	____Painful	____Spotting in between cycle
____Breast lumps	____Tightness in chest	____Hormonal problems
____Emotional changes		

VAGINAL DISCHARGE:

____White ____Yellow ____Thick ____Bad Odor ____Clear

OVULATION SYMPTOMS:

Are you aware when ovulation occurs? ____Yes ____No

If so, please describe the symptoms or sensations _____

Menopausal problems? ____Yes ____No

Please describe: _____

_____