## GENERAL INFORMATION

Have you had any of the following types of health care? ☐ Acupuncture ☐ Chiropractic ☐ Massage Therapy

When was the last time you received treatment (general)? Acupuncture _____ Chiro _____ MT _____

Are you presently under a doctor's care? ☐ No ☐ Yes Who/What: _____

Are there any other therapies which you are involved? ☐ No ☐ Yes Who/What: _____

## FOCUS

What is the primary reason for seeking care in our office? _____

Are you interested in: ☐ Pain relief ☐ Performance care ☐ Maintenance care ☐ Preventative care ☐ Holistic Health

☐ Stress relief ☐ Oriental nutrition ☐ Meridian yoga ☐ Herbal therapy ☐ _____

What do you hope to gain from your visit/treatment? ☐ Reduce symptoms ☐ How to prevent symptoms from occurring again

☐ Resume/Increase activity ☐ Learn how to take care of the symptoms on my own ☐ _____

What are your health goals? _____

Indicate any significant trauma and their occurrences (auto accident, falls, emotional, sexual, etc) ☐ None

_____

Indicate any exercise and sport activities you have been or are currently involved in ☐ None

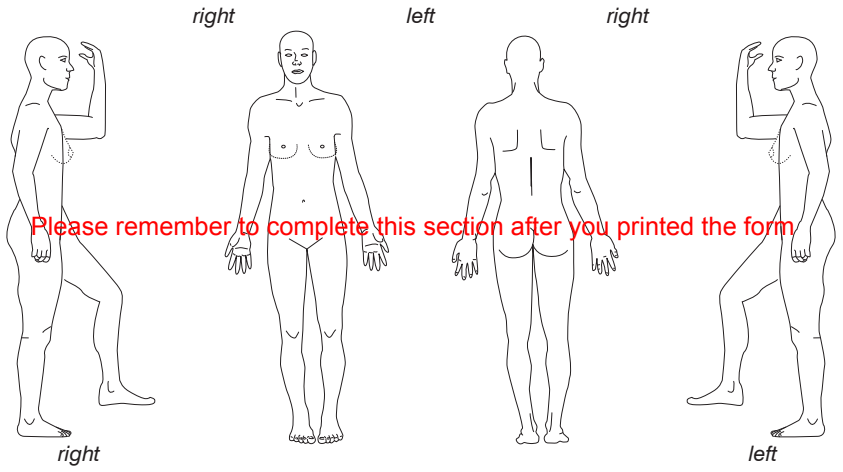
_____

## SYMPTOMS & PAIN

Identify **CURRENT** symptomatic areas in your body by marking letters on the figures (right).

- Use the letters provided in the key to identify the symptoms you are feeling
- **CIRCLE** the area around each letter, representing the size and shape of each symptom location

SYMPTOM KEY
N = numbness or tingling
P = Pain
S = joint or muscle stiffness




Please remember to complete this section after you printed the form

What was the initial cause of the symptoms? _____

When did the present symptoms appear? _____

Have you ever had similar symptoms in the past? ☐ No ☐ Yes

Explain: _____

Who did you receive treatment from? _____

How often do you experience them during the day? ☐ Intermittent *(0-25%)* ☐ Occasional *(26-50%)* ☐ Frequent *(51-75%)* ☐ Constant *(76-100%)*

Describe the nature of your symptoms? ☐ Sharp ☐ Shooting ☐ Dull Ache ☐ Burning ☐ Numb ☐ Tingling ☐ _____

How are your symptoms changing? ☐ Improving ☐ Same ☐ Getting worse

What makes your symptoms worse? _____

What makes your symptoms better? _____

What activities do your symptoms interfere with? ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Standing ☐ Bending ☐ Stretching

☐ Emotional ☐ Relationships ☐ Social Life ☐ Sexually ☐ Recreationally ☐ _____



Name: DOB: Sex: DOS:

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Have your seen or are you seeing anyone else for your symptoms? ☐No ☐Yes

Type of provider _____ When _____ Treatment _____

Have you had any tests for your symptoms? ☐No ☐Yes

☐Xrays (date _____) ☐CT Scan (date _____) ☐MRI (date _____) ☐ _____

RATING SCALE (1-10, 1 being nothing and 10 being most severe)

Symptoms at their worst: 1 2 3 4 5 6 7 8 9 10 Symptoms at their best: 1 2 3 4 5 6 7 8 9 10

How symptoms affect your ability to perform daily activities: 1 2 3 4 5 6 7 8 9 10

Pain level TODAY: 1 2 3 4 5 6 7 8 9 10

## MEDICAL HISTORY

Allergies: ☐None _____

Medications *(including over-the-counter and herbal/supplements)* ☐None

| *name* | *reason for taking* | *name* | *reason for taking* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Indicate any relevant surgical procedures and their dates (past and future) ☐None

## SIGNS/SYMPTOMS/CONDITIONS *(P = past, C = current)*

| P | C | | P | C | | P | C | | P | C | | P | C | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Abdominal pain/distension | ☐ | ☐ | Degenerative disk/spine | ☐ | ☐ | Hip/Upper leg pain | ☐ | ☐ | Muscle cramps/pain | ☐ | ☐ | Shortness of breath |
| ☐ | ☐ | Abuse survivor | ☐ | ☐ | Depression | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | Muscular incoordination | ☐ | ☐ | Sinus pressure |
| ☐ | ☐ | Acid regurgitation | ☐ | ☐ | Diabetes | ☐ | ☐ | Impotence | ☐ | ☐ | Nasal congestion | ☐ | ☐ | Sinusitis, chronic |
| ☐ | ☐ | Acne | ☐ | ☐ | Diarrhea | ☐ | ☐ | Increased libido | ☐ | ☐ | Neck/Shoulder pain | ☐ | ☐ | Skin fungal infection |
| ☐ | ☐ | Anemia | ☐ | ☐ | Digestive conditions | ☐ | ☐ | Indigestion | ☐ | ☐ | Neurological disorders | ☐ | ☐ | Smoking/Tobacco use |
| ☐ | ☐ | Angina | ☐ | ☐ | Dizziness/vertigo | ☐ | ☐ | Infection | ☐ | ☐ | Night sweat | ☐ | ☐ | Spots in eyes |
| ☐ | ☐ | Appetite loss | ☐ | ☐ | Drug/Alcohol dependence | ☐ | ☐ | Intestinal pain/cramps | ☐ | ☐ | Nocturnal emission | ☐ | ☐ | Sore throat |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Dry mouth/throat | ☐ | ☐ | Irritable | ☐ | ☐ | Nose bleeds | ☐ | ☐ | Stroke |
| ☐ | ☐ | Asthma | ☐ | ☐ | Ear aches | ☐ | ☐ | Irregular menstrual cycle | ☐ | ☐ | Numbness/Tingling | ☐ | ☐ | Sudden energy drop |
| ☐ | ☐ | Bad breath | ☐ | ☐ | Elbow/Upper arm pain | ☐ | ☐ | Itchy eyes | ☐ | ☐ | Odorous stools | ☐ | ☐ | Sweat easily |
| ☐ | ☐ | Bladder infection/UTI | ☐ | ☐ | Enlarged thyroid | ☐ | ☐ | Itchy skin | ☐ | ☐ | Osteoporosis | ☐ | ☐ | Swelling |
| ☐ | ☐ | Blood clots | ☐ | ☐ | Epilepsy/Seizures | ☐ | ☐ | Jaw pain | ☐ | ☐ | Pain upon urination | ☐ | ☐ | Swollen glands |
| ☐ | ☐ | Blood in stool | ☐ | ☐ | Excessive phlegm | ☐ | ☐ | Joint pain | ☐ | ☐ | Painful menstrual cycle | ☐ | ☐ | Teeth/Gum problem |
| ☐ | ☐ | Blood in urine | ☐ | ☐ | Excessive saliva | ☐ | ☐ | Joint swelling/stiffness | ☐ | ☐ | Peculiar tastes | ☐ | ☐ | Tumor |
| ☐ | ☐ | Blurry vision | ☐ | ☐ | Eye pain/strain/tension | ☐ | ☐ | Kidney disorders | ☐ | ☐ | Pitted edema | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Breast lump/pain | ☐ | ☐ | Fatigue | ☐ | ☐ | Kidney stones | ☐ | ☐ | PMS | ☐ | ☐ | Ulcerations |
| ☐ | ☐ | Broken bones | ☐ | ☐ | Fever | ☐ | ☐ | Knee/Lower leg pain | ☐ | ☐ | Poor appetite | ☐ | ☐ | Upper back pain |
| ☐ | ☐ | Bruise easily | ☐ | ☐ | Frequent urination | ☐ | ☐ | Laxative use | ☐ | ☐ | Poor circulation | ☐ | ☐ | Urgent urination |
| ☐ | ☐ | Cancer | ☐ | ☐ | Gas/Belching | ☐ | ☐ | Limited range of motion | ☐ | ☐ | Poor memory | ☐ | ☐ | Vaginal clotting |
| ☐ | ☐ | Chest pain | ☐ | ☐ | Gout | ☐ | ☐ | Liver/gallbladder disorder | ☐ | ☐ | Poor sleep | ☐ | ☐ | Vaginal discharge |
| ☐ | ☐ | Chills | ☐ | ☐ | Grinding Teeth | ☐ | ☐ | Loss of hair | ☐ | ☐ | Pregnancy | ☐ | ☐ | Vaginal pain |
| ☐ | ☐ | Cold hands/feet | ☐ | ☐ | Hand pain | ☐ | ☐ | Low back pain | ☐ | ☐ | Premature ejaculation | ☐ | ☐ | Vaginal sores |
| ☐ | ☐ | Concussion | ☐ | ☐ | Headache | ☐ | ☐ | Low blood pressure | ☐ | ☐ | Prostate problems | ☐ | ☐ | Varicose veins |
| ☐ | ☐ | Confusion | ☐ | ☐ | Hemorrhoids | ☐ | ☐ | Lupus, systemic | ☐ | ☐ | Psoriasis | ☐ | ☐ | Visual disturbances |
| ☐ | ☐ | Congestive heart failure | ☐ | ☐ | Heart attack | ☐ | ☐ | Mental Illness | ☐ | ☐ | Rash/dermatitis/eczema | ☐ | ☐ | Vomiting |
| ☐ | ☐ | Constipation | ☐ | ☐ | Heart palpitations | ☐ | ☐ | Mid back pain | ☐ | ☐ | Redness of eyes | ☐ | ☐ | Wake to urination |
| ☐ | ☐ | Cough | ☐ | ☐ | Hepatitis | ☐ | ☐ | Migraine | ☐ | ☐ | Rheumatoid arthritis | ☐ | ☐ | Weigh loss/gain |
| ☐ | ☐ | Coughing blood | ☐ | ☐ | Hiccup | ☐ | ☐ | Mouth sores | ☐ | ☐ | Scoliosis | ☐ | ☐ | Wheezing |
| ☐ | ☐ | Dark stools | ☐ | ☐ | High blood pressure | ☐ | ☐ | Mucous in stool | ☐ | ☐ | Short temper | ☐ | ☐ | Wrist pain |
| ☐ | ☐ | Decreased libido | | | | | | | | | | | | |

## ADDITIONAL PROVIDER COMMENTS

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