FAMILY CHIROPRACTIC ASSOCIATES

Acupuncture Patient Health Record

Legal Name (First & Last Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name/Nickname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_ Weight \_\_\_\_\_\_lbs.

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_

Cell Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours/Week \_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If a friend or Healthcare Provider, whom may we thank?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please complete this questionnaire as thoroughly as possible. Thank you.*

**1. Have you received acupuncture before? Y N**

**2. Are you currently receiving health care? Y N If yes, where and from whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. Do you have any reason to believe that you are pregnant? Y N**

**4. Do you have any chronic illness OR infectious diseases? Y N If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5**. **Please check the following if applicable:**

 ❑ I have breast implants ❑ I have a pacemaker ❑ I am taking lithium ❑ I am taking Blood Thinners (Coumadin, Warafin, Heparin)

**6. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include the type of reaction):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7. Please list any conditions, symptoms, or health concerns, *in order of importance*, that you are seeking treatment for today:**

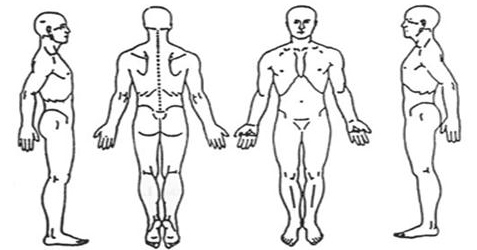
*Health concern How long have you experienced this condition?:*

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**8. If you are currently experiencing pain, or if you have discomfort**

**anywhere in your body, please indicate by marking the illustration**

**using the letters that best describes the pain and/or sensations**

**that you are experiencing.**

If the pain radiates or moves, please indicate the direction using arrows.

P- pain F- fixed D- dull A- aching

S- sharp/stabbing T –tingling N- numb

C- cramping \* - scarring B- burning

**9. Identify up to 3 important activities that you are unable to do or are having difficulty with because of your main problem.**

**Please rate them from 0-10.** (0- being unable to perform activity) to (10- being able to perform activity at the same level as before injury /problem)

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/ 10 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/ 10 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/ 10**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **GENERAL**  \_\_\_ Poor Appetite  \_\_\_ Change in Appetite  \_\_\_ Fatigue/ Low Energy  \_\_\_ Fevers  \_\_\_ Chills  \_\_\_ Night Sweats  \_\_\_ Hot Flashes  \_\_\_ Sweat Easily  \_\_\_ Run Cold  \_\_\_ Run Warm  \_\_\_ Weight Loss  \_\_\_ Weight Gain  **SLEEP**  \_\_\_ Poor Sleep  \_\_\_ Sleep Apnea  \_\_\_ Trouble Falling to  Sleep  \_\_\_ Waking Frequently  \_\_\_ Waking Early  \_\_\_ Dream-disturbed  \_\_\_ Nightmares  **NEUROLOGIC**  \_\_\_ Seizures or Tremors  \_\_\_ Paralysis  \_\_\_ Muscle Weakness  \_\_\_ Numbness / Tingling  \_\_\_ Easily Stressed  \_\_\_ Vertigo  \_\_\_ Dizziness  \_\_\_ Faintness  \_\_\_ Loss of Balance  \_\_\_ Areas of Numbness  \_\_\_ Restless Leg  Syndrome  **MENTAL / EMOTIONAL**  \_\_\_ High Stress  \_\_\_ Mood Swings  \_\_\_ Anxiety  \_\_\_ Depression  \_\_\_ Bipolar  \_\_\_ Poor Concentration  \_\_\_ Poor Memory  \_\_\_ Angry Outbursts  \_\_\_ Irritability  \_\_\_ Weepy  \_\_\_ Sadness  \_\_\_ Grief  \_\_\_ Indecision | **CARDIOVASCULAR**  \_\_\_ Chest Pain / Pressure  \_\_\_ Shortness of Breath  \_\_\_ Irregular Heart Beat  \_\_\_ Blood Clots  \_\_\_ Palpitations  \_\_\_ Swelling of Hand or  Feet  **CIRCULATION**  \_\_\_ Easy Bleeding/  Bruising  \_\_\_ Anemia  \_\_\_ Deep Leg Pain  \_\_\_ Varicose Veins  \_\_\_ Cold hands/feet  \_\_\_ Spontaneous Sweat  **MUSCLE / JOINT / BONES**  \_\_\_ Neck Pain  \_\_\_ Jaw Pain  \_\_\_ Shoulder Pain  \_\_\_ Arm/Wrist Pain  \_\_\_ Knee Pain  \_\_\_ Low Back Pain  \_\_\_ Upper/Mid Back  Pain  \_\_\_ Sciatica  \_\_\_ Heaviness of Limbs  \_\_\_ Muscle Pain/Tension  \_\_\_ Muscle spasms /  cramps  \_\_\_ Joint Pain  \_\_\_ Weak/Sore Lower  Body  \_\_\_ Loss of Strength  \_\_\_ Tingling Sensations  **HEAD / NECK**  \_\_\_ Headaches  \_\_Forehead  \_\_Temples/Sides  \_\_Top of Head  \_\_Back of Head  \_\_Behind the Eyes  \_\_\_ Migraines  \_\_\_ TMJ Disorder  \_\_\_ Swollen Glands  \_\_\_ Goiter | **NOSE & SINUSES**  \_\_\_ Frequent Colds  \_\_\_ Nose Bleeds  \_\_\_ Sinus Congestion  \_\_\_ Frequent Runny  Nose  \_\_\_ Hay Fever  \_\_\_ Sinus Problems  \_\_\_ Loss of Smell  **MOUTH & THROAT**  \_\_\_ Sore Throat  \_\_\_ Copious Saliva  \_\_\_ Teeth Grinding  \_\_\_ Sore Tongue/Lips  \_\_\_ Gum Problems  \_\_\_ Hoarseness  **SKIN**  \_\_\_ Rashes  \_\_\_ Eczema  \_\_\_ Psoriasis  \_\_\_ Acne, Boils  \_\_\_ Redness of Skin  \_\_\_ Itching  \_\_\_ Fungal Infections  \_\_\_ Skin Discoloration  \_\_\_ Hair Loss  \_\_\_ Dry Skin/Scalp  \_\_\_ Greasy Hair  \_\_\_ Change in Hair  Texture  \_\_\_ Weak / Ridged Nails  \_\_\_ Recent Moles  **EYES / EARS**  \_\_\_ Itchy Eyes  \_\_\_ Watery Eyes  \_\_\_ Dry Eyes  \_\_\_ Swollen/Painful Eyes  \_\_\_ Red Eyes  \_\_\_ Blurred Vision  \_\_\_ Spots in Vision  \_\_\_ Cataracts  \_\_\_ Color Blindness  \_\_\_ Double Vision  \_\_\_ Glaucoma  \_\_\_ Hearing Difficulty  \_\_\_ Ringing in Ears  \_\_\_ Earaches/ Infection | **RESPIRATORY**  \_\_\_ Chest Congestion  \_\_\_ Chest Tightness  \_\_\_ Wheezing  \_\_\_ Shortness of Breath  \_\_\_ Difficulty Inhaling  \_\_\_ Difficulty Exhaling  \_\_\_ Phlegm  \_\_\_ Chronic Cough  \_\_\_ Coughing Blood  \_\_\_ Bronchitis  \_\_\_ Pneumonia  **ENDOCRINE**  \_\_\_ Hypothyroid  \_\_\_ Heat Intolerance  \_\_\_ Cold Intolerance  \_\_\_ Hypoglycemia  \_\_\_ Diabetes  \_\_\_ Excessive Thirst  \_\_\_ Excessive Hunger  \_\_\_ Seasonal Depression  **DIGESTION**  \_\_\_ Abdominal Pain/  \_\_ Sharp  \_\_ Burning  \_\_ Distending  \_\_\_ Trouble Swallowing  \_\_\_ Heartburn/Acid  Reﬂux  \_\_\_ Change in Appetite  \_\_ Excessive Hunger  \_\_ Gnawing Hunger  \_\_ Poor Appetite  \_\_\_ Change in Thirst  \_\_\_ Nausea  \_\_\_ Vomiting  \_\_\_ Bad Breath  \_\_\_ Gas  \_\_\_ Bloating  \_\_\_ Belching  \_\_\_ Pain or Cramps  \_\_\_ Hemorrhoids  \_\_\_ Itchy Anus  \_\_\_ Burning Anus  **IMMUNE**  \_\_\_ Chronic Fatigue  \_\_\_ Chronic Infections  \_\_\_ Slow Wound  Healing | **GENITO-URINARY**  \_\_\_ Painful Urination  \_\_\_ Burning Urination  \_\_\_ Frequent Urination  \_\_\_ Difficult Urination  \_\_\_ Dark Urine  \_\_\_ Pale Urine  \_\_\_ Blood in Urine  \_\_\_ Cloudy Urine  \_\_\_ Night Urination  \_\_\_ Copious Urination  \_\_\_ Scanty Urination  \_\_\_ Incontinence  \_\_\_ Urinary Tract  Infections  \_\_\_ Kidney Stones  **BOWEL MOVEMENTS**  How Often? \_\_\_\_\_\_\_\_\_\_  Stools:  \_\_\_ Hard  \_\_\_ Firm  \_\_\_ Soft  \_\_\_ Loose  \_\_\_ Dry  \_\_\_ Undigested Food  \_\_\_ Mucous  \_\_\_ Black/Bloody  \_\_\_ Difficult to Pass  \_\_\_ Pellet Size  \_\_\_ Well Formed  \_\_\_ Foul Odor  \_\_\_ Diarrhea  \_\_ with Pain  \_\_ no Pain  \_\_\_ Constipation  \_\_\_ IBS  **MENS HEALTH**  \_\_\_ Frequent Urination  \_\_\_ Delayed Stream  \_\_\_ Dribbling  \_\_\_ Prostate Problems  \_\_\_ Fertility Problems  \_\_ Premature Ejaculation  \_\_\_ Erectile Dysfunction  \_\_\_ Impotence  \_\_\_ Groin Pain  \_\_\_ Testicular Pain  \_\_\_ Low Libido  \_\_\_ Testicular Masses  \_\_\_ Discharge or Sores  \_\_\_Incontinence |

**10. HEALTH HISTORY: List any major traumas such as accidents, surgeries, mental/emotional problems, significant work/ family changes ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**11. Check each that you currently use:**

❑ Laxatives ❑ Antacids ❑ Pain Relievers ❑ Cortisone ❑ Bronchodilators ❑ Antibiotics ❑ Sleeping Aids ❑ Antidepressants

**1**

**12. *Please indicate or attach a full list of medications/supplements, dosages and duration taken.***

| Current Medications, Supplements & Herbs | Dosage | For What Condition | How Long |
| --- | --- | --- | --- |
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**13. Lifestyle:**

**a. Please describe your typical daily food intake on the average day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**b. Exercise: What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**c. Sleep Habits: # of hours/night \_\_\_\_\_ Dreams? Y / N Quality? Good / Poor Wake rested? Y / N**

**d. Nicotine/Alcohol/Caffeine Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**e. # of Hours per day of: Television \_\_\_\_\_\_\_\_\_\_\_ Reading\_\_\_\_\_\_\_\_\_\_\_\_ Computer work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**f. Interests & Hobbies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**12. FAMILY HISTORY: List any major disease or illness in your immediate family (and indicate family member)**

(such as: Heart Disease, Cancers, Diabetes, High Blood Pressure, Auto-Immune Conditions, Stroke, etc):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**14. FEMALE Reproductive** (please **CIRCLE any that you experience now**, and **underline any that you have experienced in the past**):

Irregular Cycles Heavy Flow Scanty Flow Bleeding Between Cycles Amenorrhea

PMS Headaches w/menses Constipation w/menses Diarrhea w/menses Breast Tenderness

Uterine Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID

PCOS Menopausal Symptoms Pelvis adhesions/scarring Decreased Libido Vaginal Dryness

Vaginal Itching Uterine Prolapse Difficulty Conceiving Breast Lumps STD::\_\_\_\_\_\_\_\_\_\_\_\_

Breast Lumps Pain w/Intercourse Vaginal Odor Vaginal Burning Nipple Discharge

**Menstrual/Birthing History:**  Age of First Menses: \_\_\_\_\_ # of Days of Menses: \_\_\_\_\_ Length of Cycle: \_\_\_\_\_days

# of Pregnancies: \_\_\_\_\_ # of Miscarriages: \_\_\_\_\_ # of Abortions: \_\_\_\_\_ # of Live Births: \_\_\_\_\_ Age of menopause \_\_\_\_\_

Date of last gynecological exam & results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active? ❑ Yes ❑ No Do you practice Birth Control? ❑ Yes ❑ No If so, which Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not currently, have you ever taken the birth control pill? ❑ Yes ❑ No Have you used an IUD? ❑ Yes ❑ No

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**