Name: ____ Date of Birth: ________________

Address: ____

City/State: _________________________________ Zip Code: ______________________________

Home Phone:_______________ Cell:_______________________ Work:________________________

Email: ____

Would you like to receive appointment reminders via text? YES / NO

Employment Status: (check one) ☐ Employed ☐ FT/PT Student ☐ Retired ☐ Other

Employer:___________________________ How Long: ___________________

Occupation/Title: ____

Please describe your daily work habits and enviroment: _____________________________________

____

Gender: Male / Female Martial Status: Single / Married / Other

Emergency Contact Name: ____

Emergency Contact Phone Number:____

How did you hear about me? ____

Please identify the condition(s) that brought you to this office:

Primary: ____

Secondary: ____

When and how did the problem(s) begin? ____

When is the problem(s) at its worst? ____

What is the frequency of discomfort? Contnuous / Intermittent / Occasional / Frequent

Was the condition treated by anyone in the past? YES / NO

If yes, by Whom?_____________________________ What were the results?___________________

Have you had acupuncture before? YES / NO Chinese Herbal Medicine? YES / NO

Have you ever seen a chiropractor? YES / NO

If yes, by Whom?____________________ When?_________________________________

Do you currently use tobacco of any kind? Yes / Former User / Never

If yes, how often? current every day / current occasional

Do you currently drink alcoholic beverage of any kind? Yes / Former User / Never

If yes, how often? current every day / current occasional

If yes, what is your level of interest in quitting? (1=not intrested-10 very intresed):_____

Please describe your current fitness routine: ____

____

Current medications, vitamins, and herbal supplements (frequency and dosage). If none, check here ☐

	Start Date		Start Date
1		5	
2		6	
3		7	
4		8	

List any medicine or enviromental allergies you have had. If no allergies are known, check here ☐

1	Reaction:	
2	Reaction:	
3	Reaction:	
4	Reaction:	

Please list any major injuries, illness, surgeires and treatments you have had or have:

Illness:

☐ AIDS/HIV Positive
☐ Alcoholism
☐ Allergies
☐ Arteriosclerosis
☐ Cancer
☐ Chicken Pox
☐ Diabetes
☐ Epilepsy
☐ Glaucoma
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Malaria
☐ Measles
☐ Multiple Sclerosis
☐ Mumps
☐ Polio
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sexually transmitted disease
☐ Stroke
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Headaches

Operations:

☐ Appendix
☐ Bypass Surgery
☐ Cancer
☐ Eye Surgery
☐ Hysterectomy
☐ Pacemaker
☐ Spine
☐ Tonsillectomy
☐ Vasectomy
☐ Physical Therapy
☐ Hernia Repair
☐ Other:______________________

Review of System

Please check any of the following you have/had in the past:

Constitutional

☐ Fainting ☐ Poor appetite ☐ Sweat easily
☐ Low libido ☐ Poor sleep ☐ Night sweat
☐ Fatigue ☐ Troble spleeing ☐ Sudden weight: Loss / Gain
☐ Weakness ☐ Strong thirst ☐ Cravings: Sugar / Salt / Sour / Spicy

Musculoskeletal

☐ Osteoporosis ☐ Back pain ☐ Shoulder issues
☐ Arthritis ☐ Hip problems ☐ Elbow/Wrist issues
☐ Scoliosis ☐ Knee problems ☐ TMJ issues
☐ Neck pain ☐ Foot/Ankle ☐ Poor posture

Neurological

☐ Anxiety ☐ Dizziness ☐ Numbness
☐ Depression ☐ Pins & Needles ☐ Tremors
☐ Bad Temper ☐ Poor Memory ☐ Loss of Balance

Cardiovascular

☐ High Blood Pressure ☐ Poor Circulation ☐ Chest Pain or Tightness (Angina)
☐ Low Blood Pressure ☐ Bruise Easily ☐ Swelling of Hands
☐ High Cholesterol ☐ Excessive Bruising ☐ Swelling of Feet
☐ Irregular Heartbeat ☐ Cold Hands or Feet ☐ Other: _______________

Respiratory

☐ Asthma ☐ Emphysema ☐ Pneumonia
☐ Sleep apnea ☐ Hay fever ☐ Shortness of breath
☐ Cough ☐ Difficulty breathing when lying down

Digestive

☐ Anorexia ☐ Food Sensitivities ☐ Constipation
☐ Bulimia ☐ Heartburn ☐ Diarrhea
☐ Nausea ☐ Indigestion ☐ Bloating
☐ Belching ☐ Gas ☐ Bad Breath

Sensory

☐ Blurred vision ☐ Hearing Loss ☐ Loss of Smell
☐ Ears ringing ☐ Chronic ear infection ☐ Loss of Taste

Integumentary

☐ Skin cancer ☐ Eczema ☐ Rash
☐ Psoriasis ☐ Acne ☐ Hair Loss

Endocrine

☐ Thyroid issues ☐ Hypoglycemia ☐ Swollen glands
☐ Immune disorders ☐ Frequent infection ☐ Low Energy

Genitourinary

☐ Kidney stones ☐ Prostate issues ☐ Urgent urination
☐ Infertility ☐ Frequent urination ☐ Unable to hold urine
☐ Erectile Dysfunction ☐ Painful urination ☐ Other: _______________

Does anyone in you family suffer with the same condition(s)? YES / NO
If yes, whom and which condition: ____

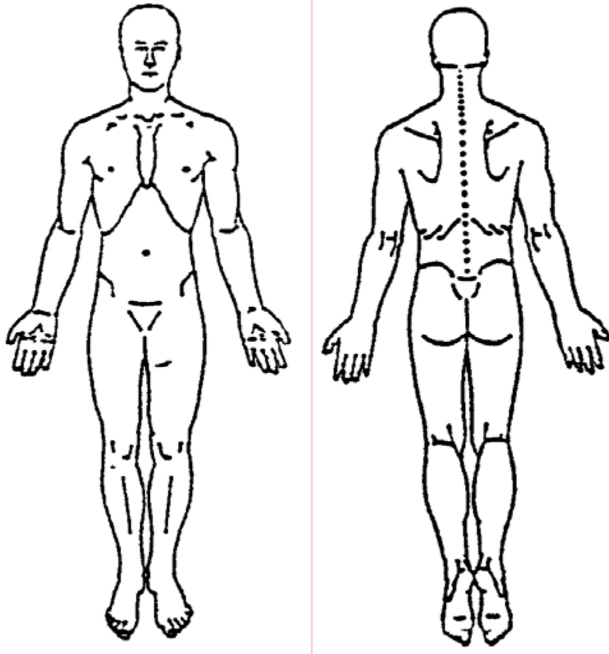
Treatment:

☐ Antibiotics ☐ Dialysis ☐ Inhaler
☐ Chemoterapy ☐ Hormone Replacement ☐ Massage

Injury:

☐ Broken bone(s): ____________
____
☐ Car Accident (what year):_____
____
☐ Knocked Unconscious
☐ Spine Disorder
☐ Nerve Disorder
☐ Hernia

Indicate Painful or Dristress areas.



How severe is the pain:
1 2 3 4 5 6 7 8 9 10

Typer of pain:
☐ Sharp ☐ Local
☐ Dull ☐ Radiates
☐ Achy ☐ Other: ____________

How frequent is the pain:
☐ Continuous
☐ Intermittent
☐ Occasional

Reproductive & Gynecology (Female Patients Only)

MENSTRUAL CYCLE: YES NO (Age it stopped_____)
Age of first Period: __________
First day of last Period: __________
Length of Period: __________
Length of cycle: __________
Flow: Light / Moderate / Heavy
Pain or Cramps: Before / During / After
Color: Pink / Bright Red / Red / Dark Red / Brown-Black
Clots: Small / Big Color of Clots: Dark -Red / Pale

BIRTHING HISTORY:
Currently Breastfeeding YES NO
Number of Pregnancies __________
Ectopic Pregnancies __________
Live Births __________
C-Sections __________
Still Births __________
Miscarriages __________
Abortions __________

Other symptoms during your period:

☐ PMS ☐ Constipation ☐ Night Sweating ☐ Other: _______________
☐ Headache ☐ Diarrhea ☐ Low Back Pain ______________________
☐ Insomnia ☐ Nausea ☐ Acne

Sexualy Active: YES NO
Possible Pregnancy: YES NO

Birth Control: YES NO
Type: ________________________________
How Long: __________