FAMILY CHIROPRACTIC ASSOCIATES

Acupuncture Patient Health Record

Legal Name (First & Last Name) ____ Preferred Name/Nickname ___________________
Address ____ City _____________________ State _____ Zip ___________
Cell Telephone ______________________ Home Telephone _____________________ Work Telephone _______________________
E-mail____
Date of Birth ______________________ Gender ________________ Height ______________ Weight __________lbs.
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):

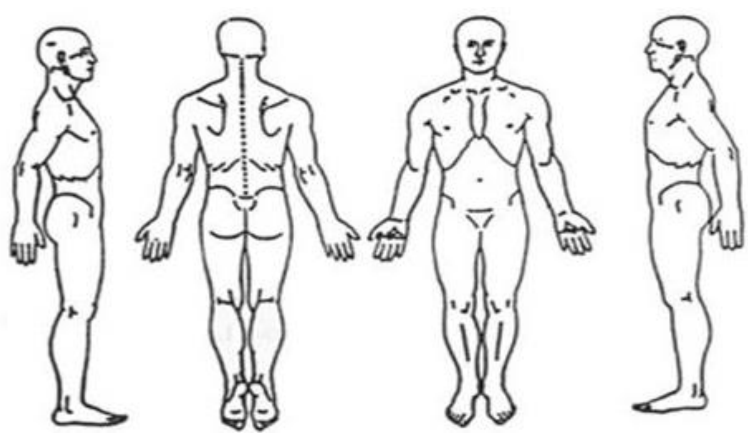
____

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. ____

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

____

____

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. Check each that you currently use:

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

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

Current Medications, Supplements & Herbs	Dosage	For What Condition	How Long

11. 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 and 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):

____

13. 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________________