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