

# ADVANCED HEALTH CHIROPRACTIC

## ACUPUNCTURE PAPER WORK

*Important:* Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

*All information is strictly confidential*

### GENERAL INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you lost or gained weight recently? If so, how much, were you trying to, and over how much time? \_\_\_\_\_

Address \_\_\_\_\_

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

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_

Email: \_\_\_\_\_

Can we leave a message if necessary? \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone: \_\_\_\_\_

Have you had acupuncture before? Yes No

If yes, list condition(s) treated?

\_\_\_\_\_

Referred by: \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_

Date of last visit? \_\_\_\_\_ Reason? \_\_\_\_\_

How long has it been since you have had a complete medical exam? \_\_\_\_\_

### Major Complaint

What is your primary reason for this visit?

\_\_\_\_\_

What do you think is the cause of this condition? \_\_\_\_\_

How long have you had this condition? Is it getting worse? \_\_\_\_\_

\_\_\_\_\_

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Does this condition interfere with your Sleep/ Work/ Other \_\_\_\_\_

Have you received treatment for this complaint? Yes No

If yes, what was done? \_\_\_\_\_

Did it help? Not at all/ Somewhat/ Very effective/ Not sure

Do you have any specific questions that you would like to discuss today? \_\_\_\_\_

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## DIET

What did you eat for breakfast, lunch and dinner yesterday?(Breakfast , lunch, dinner, snacks)

\_\_\_\_\_

\_\_\_\_\_

Was this a typical day for you? \_\_\_\_ Yes \_\_\_\_ No

Do you consume alcohol? \_\_\_\_ Yes \_\_\_\_ No If yes, how many times per week? \_\_\_\_\_

Do you consume caffeine? \_\_\_\_ Yes \_\_\_\_ No If yes, how many times per week? \_\_\_\_\_

List medications or food supplements you are taking.

\_\_\_\_\_

\_\_\_\_\_

List serious illnesses, accidents or surgeries.

\_\_\_\_\_

\_\_\_\_\_

### Check illnesses that have occurred in blood relatives.

\_\_Diabetes \_\_High blood pressure \_\_Stroke \_\_Cancer \_\_Heart disease \_\_Kidney disease

Other \_\_\_\_\_

### Check symptoms you have or have had in the last year, circle if currently experiencing symptoms:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Difficulty in focusing | <input type="checkbox"/> Dizziness      |
| <input type="checkbox"/> Easily startled          | <input type="checkbox"/> Excessive anger        | <input type="checkbox"/> Excessive fear |
| <input type="checkbox"/> Excessive worry          | <input type="checkbox"/> Fatigue/tiredness      | <input type="checkbox"/> Headaches      |
| <input type="checkbox"/> Loss of sleep/poor sleep | <input type="checkbox"/> Loss or gain of weight |   |
| <input type="checkbox"/> Nervousness/irritability | <input type="checkbox"/> Overwhelmed by life    |   |

### Check conditions you have or have had in the past:

- |                                    |   |                                      |
|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> AIDS      | <input type="checkbox"/> Allergies          | <input type="checkbox"/> Anemia      |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Diabetes           |                                      |

Check symptoms you have or have had in the last year:

**MUSCLE/JOINT/BONES**

- Tremors and/or Cramps
- Swollen joints

**Pain, weakness, numbness in:**

- Arms or Hips
- Back Legs
- Feet
- Neck
- Hands
- Shoulders
- Other \_\_\_\_\_

**EYES/EAR/NOSE/THROAT/RESPIRATORY**

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Gum trouble
- Hay fever
- Hoarseness
- Loss of hearing
- Nose bleeds
- Persistent cough
- Ringing in ears
- Sinus problems

**SKIN**

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

**GENITO/URINARY**

- Blood/pus in urine
- Frequent urination
- Lowered libido
- Inability to control urine
- Kidney infection/stones

**CARDIOVASCULAR**

- Chest pain
- Hardening of arteries
- Pain over heart
- High or low blood pressure
- Previous heart attack
- Poor circulation
- Rapid/irregular heart beat
- Swelling of ankles

**GASTROINTESTINAL**

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Excessive hunger
- Distention of abdomen
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

**FOR MEN ONLY**

- Erection difficulties
- Penis discharge
- Prostate trouble

**FOR WOMEN ONLY**

- Bleeding between periods
  - Excessive menstrual flow
  - Menopausal symptoms
  - Scanty menstrual flow
  - Clots in menses
  - Extreme menstrual pain
  - Previous miscarriage #\_\_\_\_\_
  - Irregular cycle
  - PMS
  - Live Births #\_\_\_\_\_
- Could you be pregnant?\_\_\_\_\_

**HEAD**

- Headaches
- Forgetful
- Difficulty concentrating
- Head feels heavy
- ADD/ ADHD
- Changes in hair

**EMOTIONAL WELL-BEING**

**CHILDHOOD**

- Childhood Stress
- Personal relationships
- School Stress
- Stress of being sick
- Family Stress
- Abuse

**ADULTHOOD**

- Work related stress
- Relationship stress
- Change in vocation
- Stress of commuting
- Change in lifestyle
- Loss of loved one
- Abuse

**GRADE YOUR MENTAL HEALTH**

- Excellent
- Poor
- Good
- Getting Better
- Fair
- Getting Worse

Patient Print Name : \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_