

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? _____

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: _____