Intake Form

Patient Name: _____ Today's Date: _____

Address: _____Apt#_____ City: _____ State: ____ Zip: _____

Phone: Home: _____Cell: _____ Work: _____

Email: _____Date of Birth: _____ Age: _____

Insurance Company: _____ ID# _____ Group# _____

Gender: ☐M ☐F ☐Other Marital Status: ☐M ☐S ☐W ☐D

Social Security#: _____ Ethnicity: _____

Occupation and weekly hours you work: _____

Emergency Contact's Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Where/Who did you hear about us from: _____

Have you had acupuncture before: ☐Y ☐N Have you had chiropractic before: ☐Y ☐N

3 CHIEF COMPLAINTS YOU WOULD LIKE TO FOCUS ON:

1: _____
2: _____
3: _____

MEDICAL HISTORY (PLEASE INCLUDE DATES)

☐ Allergies: _____
☐ Cancer: _____
☐ Diabetes
☐ Hepatitis A/B/C
☐ High blood pressure
☐ Heart disease
☐ Seizures
☐ Rheumatic fever
☐ Surgeries: _____
☐ Venereal (STD) disease
☐ Thyroid disease
☐ Birth trauma (prolonged labor, forceps delivery, etc.)
☐ HIV/AIDS
☐ Other significant illnesses:
_____
_____
☐ Accidents or Hospitalizations:
_____
_____

FAMILY MEDICAL HISTORY

☐ High Cholesterol
☐ Diabetes
☐ Asthma
☐ Cancer
☐ Heart disease
☐ High blood pressure
☐ Seizures
☐ Stroke
☐ Other: _____

GENERAL (Last 6 Months)

☐ Poor appetite
☐ Insomnia
☐ Disturbed sleep
☐ Weight gain
☐ Weight loss
☐ Changes in appetite
☐ Night sweats
☐ Fever
☐ Chills

☐ Localized weakness ☐ Sweating easily ☐ Sudden energy drop
☐ Anemia ☐ Tremors (time of day?)
☐ Strong thirst ☐ Bleeding or bruising easily ☐ Poor balance
☐ Smoke(# of packs/day): ☐ Alcohol consumption(#drinks/day):

Skin and Hair

☐ Rashes ☐ Eczema ☐ Recent moles
☐ Ulcerations ☐ Pimples ☐ Changes in texture of hair or skin
☐ Hives ☐ Dandruff
☐ Itching ☐ Hair loss ☐ Other: _____

Head, Neck, Eyes, Ears, Nose, Throat

☐ Dizziness ☐ Color blindness ☐ Recent sore throats
☐ Concussions ☐ Cataracts ☐ Nose bleeds
☐ Migraines/Headaches ☐ Blurry vision ☐ Grinding teeth
☐ Glasses ☐ Earaches ☐ Sores on lips or tongue
☐ Spots in front of eyes ☐ Ringing in ears ☐ Facial pain
☐ Eye pain ☐ Poor hearing ☐ Teeth problems
☐ Poor vision ☐ Eye strain ☐ Jaw clicks/TMJ
☐ Night blindness ☐ Sinus problems ☐ Other: _____

Cardiovascular

☐ Hypertension ☐ Swelling of feet/hands ☐ Thrombophlebitis
☐ Low blood pressure ☐ Fainting ☐ Blood clots
☐ Chest pain ☐ Cold hands or feet ☐ Difficulty in breathing
☐ Irregular heartbeat ☐ Myocardial Infarction ☐ Other: _____

Respiratory

☐ Cough ☐ Bronchitis ☐ Difficulty breathing when lying down
☐ Coughing up blood ☐ Pain with deep inhalation ☐ Excessive phlegm (color?)
☐ Asthma ☐ Pneumonia ☐ Other: _____

Digestive

☐ Nausea ☐ Belching ☐ Rectal pain
☐ Vomiting ☐ Black stools ☐ Hemorrhoids
☐ Belching ☐ Blood in stools ☐ Abdominal pain or cramps
☐ Constipation ☐ Indigestion ☐ Chronic laxative use
☐ Gas ☐ IBS ☐ Other: _____

Genitourinary

☐ Pain on urination ☐ Decrease in flow ☐ Impotence
☐ Frequent/Urgent urination ☐ Incontinence ☐ Sores on genitals
☐ Blood in urine ☐ Kidney stones ☐ Other: _____

Musculoskeletal

☐ Neck pain ☐ Back pain ☐ Hand/wrist pains
☐ Muscle pains ☐ Muscle weakness ☐ Shoulder pains

☐ Knee pain ☐ Foot/ankle sprain/pain ☐ Hip pain
☐ Carpal Tunnel ☐ Sciatica ☐ Other Joint/Bone: _____

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Poor memory ☐ Anxiety
☐ Dizziness ☐ Lack of coordination ☐ Bad temper
☐ Loss of balance ☐ Concussion ☐ Easily susceptible to stress
☐ Areas of numbness ☐ Depression ☐ Other: _____

Have you ever been treated for emotional problems? ☐Y ☐N

Have you ever considered or attempted suicide? ☐Y ☐N

GYNECOLOGIC

☐ Premenstrual changes ☐ Heavy menstrual flow ☐ Premature births
☐ Menstrual clots ☐ Light menstrual flow ☐ Miscarriages
☐ Painful menses ☐ Irregular menses ☐ Abortions
☐ Unusual menses ☐ Other problems: _____

Age at first menses: ____ Age at menopause: ____ # of pregnancies: ____
Length of cycles: ____ Duration of bleeding: ____ First day of last period: ____

Current birth control method?

Are you currently pregnant? ☐Y ☐N ☐Not Sure

LIST CURRENT MEDICATIONS AND DOSAGE:

_____

_____

OTHER SIGNIFICANT HEALTH INFORMATION:

_____

_____

MARK AREAS OF PAIN AND DISCOMFORT: