Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

If you need more room, please use the other side of these sheets.

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Mobile Phone: _____ E-Mail: _____

Date of Birth: _____ Age: _____ Marital Status: _____
Occupation: _____

Physician: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Referred By:_____
In Emergency Notify: _____ Phone: _____

Main Complaint (symptoms, diagnosis, duration, type of pain, etc.)

What makes your condition better? (Rest, movement, position, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (Movement, position, stress, fatigue, hunger, heat, certain foods, damp days etc.)

How is your sleep? (How many hours/night? Hard to fall asleep? Wakes up a few times at night?

Are you usually cold or hot? Aversion to cold or heat?

Do you sweat a lot or don't sweat at all? (Night sweats, etc)

How is your energy level? (High, low)

Do you get thirsty often? (How much water do you drink/day, prefer cold or hot beverage?)

How is your diet? (Do you eat regularly? Usually eat raw food? Hot food? Spicy? Sweet? Fried?)

How is your bowel movement?

Significant Trauma/ Accident (physical or emotional)

Birth History (prolonged labor, forceps delivery, complications, etc.)

Surgeries/ Hospitalization (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Prescribed or over-the-counter Medications (names & dosages). Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise

Days per week | Length of workout | Type of Activity

Diet

Meals per day | Snacks | Caffeinated Drinks | Alcohol per week

Personal History

Please check any conditions or symptoms you have now.

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Fatigue
- ☐ Alcoholism
- ☐ Gastritis/Pancreatitis
- ☐ Liver/Gall Bladder Disease
- ☐ Hypo/Hyperglycemia
- ☐ Diabetes
- ☐ Seizures
- ☐ Anemia
- ☐ Lyme Disease
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Food Allergies/Intolerance
- ☐ Hepatitis
- ☐ Thyroid Imbalance
- ☐ Chronic Pain Condition
- ☐ Infertility
- ☐ Heart Disease
- ☐ Elevated Blood Cholesterol
- ☐ Diverticulitis/IBS
- ☐ Raynaud's Disease
- ☐ Respiratory Allergies
- ☐ Impotence
- ☐ Emphysema

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- ☐ Diabetes ___
- ☐ High Blood Pressure ___
- ☐ Other_____
- ☐ Seizures ___
- ☐ Allergies ___
- ☐ Heart Disease ___
- ☐ Cancer ___
- ☐ Stroke ___
- ☐ Asthma ___

Please check if you have had any of these items listed below in the last year
Put a circle in the box if you had this in the past but do not any longer.

General

- ☐ Poor Appetite
- ☐ Chills
- ☐ Cravings
- ☐ Bleed/Bruise easily
- ☐ Muscle weakness/fatigue
- ☐ Poor Sleeping
- ☐ Night Sweats
- ☐ Localized Weakness
- ☐ Weight loss/gain
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Sweats Easily
- ☐ Poor Balance
- ☐ Peculiar tastes/smells
- ☐ Strong thirst (hot or cold drinks)
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems

Skin and Hair

- ☐ Rashes
- ☐ Eczema/Psoriasis
- ☐ Skin discoloration
- ☐ Dermatitis
- ☐ Ulcerations
- ☐ Dandruff
- ☐ Acne
- ☐ Warts
- ☐ Hives/Allergic Dermatitis
- ☐ Loss of hair
- ☐ Change in skin/hair texture
- ☐ Fungal Infection
- ☐ Itching
- ☐ Recent moles
- ☐ Face flushing
- ☐ Weak or ridged nail

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Color Blindness
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sores on lips/tongue
- ☐ Difficulty swallowing
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Recurrent sore throats/colds
- ☐ Dental problems
- ☐ Migraines
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Spots in front of eyes
- ☐ Grinding teeth
- ☐ Jaw clicks/locks
- ☐ Glasses
- ☐ Night Blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Facial pain
- ☐ Headaches

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Cold hands/feet
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Swelling of hands/feet
- ☐ Varicose/spider veins
- ☐ Spontaneous sweating
- ☐ Palpitations at rest
- ☐ Blood clots
- ☐ Pressure in chest
- ☐ Dizziness
- ☐ Fainting
- ☐ Phlebitis
- ☐ High blood pressure

Respiratory

- ☐ Cough/Wheezing
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Coughing blood
- ☐ Pain with deep inhalation
- ☐ Asthma
- ☐ Tight sensation in chest
- ☐ Production of phlegm… what color? _____
- ☐ Bronchitis
- ☐ Difficult inhale/exhale

Gastrointestinal

- ☐ Nausea
- ☐ Gas
- ☐ Indigestion
- ☐ Bloating/Edema
- ☐ Changes in appetite
- ☐ Excessive appetite
- ☐ Vomiting
- ☐ Belching
- ☐ Bad breath
- ☐ Chronic laxative use
- ☐ Acid reflux/GERD
- ☐ Significant thirst
- ☐ Diarrhea
- ☐ Black stools
- ☐ Rectal pain
- ☐ Loose stools (>2 per day)
- ☐ Hernia
- ☐ IBS/Crohn's Disease
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Poor appetite

Genito-Urinary

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Night urination… What time?_____ How often?_____
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Decreased libido
- ☐ Pain in testicles
- ☐ Blood in urine
- ☐ Scanty flow
- ☐ Urinary tract infection
- ☐ Prostatitis
- ☐ Herpes
- ☐ Urgent urination
- ☐ Copious flow
- ☐ Burning urination
- ☐ Dribbling after urination
- ☐ Infections
- ☐ Excessive libido

Gynecological/Reproductive

- ☐ Difficult/Painful intercourse
- ☐ Vaginal dryness
- ☐ Vaginal sores
- ☐ Vaginal discharge
- ☐ Infertility
- ☐ Irregular menstruation
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Fibrocystic breast tissue
- ☐ Polycystic Ovarian Disease
- ☐ PMS
- ☐ Painful menstruation
- ☐ Age of first menses_____
- ☐ Date of last menses_____
- ☐ Date of last PAP/Pelvic_____
- ☐ Number of pregnancies____
- ☐ Number of ectopic pregancies_____
- ☐ Number of live births_____
- ☐ Number of miscarriages_____
- ☐ Number of abortions_____

Do you practice birth control?_____
What type?_____ How long?_____

Musculoskeletal

- ☐ Neck pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Back pain Low___ Middle___ Upper___
- ☐ Soreness/weakness in lower body (back, knee, hip, ankle, foot)
- ☐ Shoulder pain
- ☐ Sprains/Strains
- ☐ Muscle pain
- ☐ Hand/wrist pain
- ☐ Sciatica
- ☐ Muscle weakness
- ☐ Bursitis
- ☐ Carpal Tunnel
- ☐ Foot/ankle pain
- ☐ Tendonitis
- ☐ Rotator Cuff

Neuropsychological

- ☐ Seizures
- ☐ Lack of coordination
- ☐ Anxiety/Panic attacks
- ☐ Nervousness
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Bad temper/irritable
- ☐ ADD/ADHD
- ☐ Vertigo/Dizziness
- ☐ Concussion
- ☐ Easily susceptible to stress
- ☐ Manic Depression
- ☐ Areas of numbness
- ☐ Depression
- ☐ Seasonal Affective Disorder

Have you ever been treated for emotional problems? ☐Yes ☐No
Have you ever considered or attempted suicide? ☐Yes ☐No
Have you ever been treated for substance abuse? ☐Yes ☐No

Comments **Please inform me of any other problems you would like to discuss.**

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counselling.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately.*

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. _____
initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____
initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation.
_____
initials

I agree to pay all charges incurred for services rendered, over and above insurance coverage. _____
Initial

_____
Patient's Name

_____
Patient's Signature

_____
Date Signed

_____
Are you Pregnant?

_____

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Patient's Name_____
Patient's Representative_____
Relationship or Authority of Patient_____
Witness_____

Chiropractic consent to treatment

I _____, of _____ do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea may occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve there benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to that performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motions, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____Signature of patient

_____Signature of witness

_____ Date and time