



## FIDEL CHIROPRACTIC CENTER ACUPUNCTURE PATIENT INTAKE FORM

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

**IDENTIFICATION:**

Name \_\_\_\_\_ Sex M \_\_\_ F \_\_\_ Date \_\_\_\_\_ Email \_\_\_\_\_

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

Telephone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Separated/Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Partnered \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency contact \_\_\_\_\_ Relation \_\_\_\_\_

Emergency contact telephone: Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Name of physician \* \_\_\_\_\_

Address of physician \_\_\_\_\_

Phone number of physician ( ) \_\_\_\_\_

Date of last physician appointment \_\_\_\_\_

Date of last gynecology exam (women only) \_\_\_\_\_

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? Yes/No

\* No contact will be made with the physician without your permission.

**FAMILY HISTORY** – Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse	children
Cancer or tumors						
Diabetes						
Blood or bleeding disorders/anemia						
Seizures						
High blood pressure/heart disease						
Allergies						
Stroke						
Drug abuse						
Depression or mental illness						
Deceased (age)	n/a					
Hepatitis						
Kidney disorders						
Thyroid disorders						
Musculo-skeletal disorder						
Blood transfusion (if before 1985)						

**PERSONAL LIFESTYLE HABITS:** For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs) \_\_\_\_\_ Coffee/Tea (cups) \_\_\_\_\_ Alcohol (drinks per week) \_\_\_\_\_

**MEDICAL:** If you have ever been hospitalized for a serious medical illness or operation, please write the most recent ones below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

**MEDICINES:**

What prescription drugs are you currently taking:

For what condition?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What over-the-counter medications, herbs, or supplements are you currently taking:

For what condition?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

**General**

- Insomnia
- Dreams/ nightmares
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

**Head & Neck**

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

**Ears**

- Ringing
- Hearing loss
- Hearing aids
- Infections
- Earache
- Vertigo

**Eyes**

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

**Nose, Throat & Mouth**

- Sinus infection
- Hay fever/ allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems
- Dry mouth

**Skin**

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easily bruised
- Changes in moles, lumps
- Itching

**Respiratory**

- Difficulty breathing
- Difficulty breathing when reclining
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

**Gastrointestinal**

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool

**Musculoskeletal**

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

**Neurological**

- Seizures
- Tremors
- Numbness or tingling
- Pain (describe)
- Paralysis
- Poor coordination
- Other (describe)

**Mental/Emotional**

- Depression
- Mood swings
- Irritability
- Difficulty relaxing
- Loneliness
- Sensitive
- Shy
- Cry often
- Worry a lot
- Compulsive behaviors
- Difficulty focusing
- Hopeless outlook
- Suicidal thoughts
- Lose temper
- Frustration

**Urinary**

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones

**Male Genital**

- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

**Gynecology (Women Only)**

- Currently pregnant
- # of Pregnancies
- Miscarriages
- Abortions
- Menopause
- Hormone replacement therapy
- Irregular periods
- Menstrual cramps
- Excessive blood flow
- Menstrual blood clots
- Breast tenderness
- Abnormal pap smear
- Vaginal infections
- Vaginal pain/itching
- Uterine fibroids
- Endometriosis
- Breast lumps, cysts

**Infection Screening (circle self and/or partner)**

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea: self or partner
- Chlamydia: self or partner
- Syphilis: self or partner
- Genital warts: self or partner
- Herpes: oral/genital: self or partner

**Other Information**

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Signature

Date