PATIENT INTAKE

- EVERY patient must complete **SECTIONS 1-7**
- **If** this is related to a car accident you will also fill out the **CAR ACCIDENT ADDENDUM**
- **If** this is related to a work injury, you will also fill out the **WORK COMP ADDENDUM**
- **If** you are here for fertility treatment, you will also fill out the **FERTILITY ADDENDUM**

1 – PERSONAL INFORMATION

Name ____________________ Gender ☐ M ☐ F

SS # ____________ For minor, list parent / guardian ____________________

DOB __________ Age ______ Height ____ ' ____ Weight ______ BP (most recent reading) ______ /______

Home Address ______________________________
Street City State Zip

Home phone ____________ Cell phone ____________ Email ____________________

We keep your information **STRICTLY** confidential. Providing us with your email/phone number(s) simply allows us to contact you regarding your care while maintaining your privacy rights per HIPPA laws.

2 – EMPLOYER INFORMATION (if applicable)

Employer ____________________ Type of Job ____________________ Phone ______________

3 – REFERRAL SOURCE

Please check the box where you **FIRST** heard about us:

☐ Google search ☐ Google ad ☐ Facebook ad ☐ Phone Book ☐ Family/Friend/Patient; ______________

☐ Health Care Provider (Doctor/Masseuse/PT/etc) ☐ Golden Egg ☐ Doctor lecture ☐ Printed Ad / brochure / card

☐ Other: ______________________________

4 – ACCOUNT INFORMATION

Payment method ☐ No Insurance (Cash/Check/Credit Card) ☐ Insurance ☐ Work Comp ☐ Auto Insurance

For Personal Insurance, if you are **NOT** the **PRIMARY** policy holder, we require that person's info to bill the insurance

Name ______________________________ DOB ______________

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PATIENT INTAKE

5 – SOCIAL HISTORY (if patient is a child/infant, skip this section) NAME:

Marital:	Single / Married / Divorced / Widow / Separated				Children? Y / N (ages) ________________________				
Water (oz/day)	1-20	21-40	41-60	>60	Coffee/Soda (cups/day)	None	1-2	2-4	>4
Alcohol (drinks/wk)	None	1-5	5-10	>10	Fast Food (meals/wk)	None	1-2	2-5	>5
Exercise (times/wk)	None	1-2	3-4	>4x	Sleep (hrs/night)	1-4	5-8	>8	
Artificial Sweeteners	None	Low	Mod	Hi	Typical Appetite	Low	Mod	Hi	
Smoking Status	Never	Former	Current	______ /day	Drugs (recreational)	None	Low	Mod	Hi
Work (hrs/wk)	None	1-20	21-40	>40	Typical stress level	Low	Mod	Hi	
Physical activity level	Low	Mod	Hi		Diet	Poor	Avg	Good	

We offer weight loss counseling and products, if you would like more information, check here ☐

6 – REVIEW OF SYSTEMS

Constitutional
- ☐ Unexplained weight loss
- ☐ Night sweats / chills
- ☐ Seizures
- ☐ Fatigue
- ☐ Fevers
- ☐ Poor sleep / insomnia
- ☐ Recent trauma
- ☐ Memory problems
- ☐ Headaches
- ☐ Dizziness

EENT
- ☐ Vision (blurry/double/etc)
- ☐ Eye pain
- ☐ Runny nose / cold
- ☐ Frequent bloody nose
- ☐ Change in smell
- ☐ Sinusitis
- ☐ Sore throat
- ☐ Pain with swallowing
- ☐ Ear discharge
- ☐ Ringing in ear(s)
- ☐ Ear pain
- ☐ Difficulty talking
- ☐ Bloody gums
- ☐ Enlarged lymph node

Genitourinary
- ☐ Bed wetting
- ☐ Blood in urine
- ☐ Prostate troubles
- ☐ Dribbling / loss of control
- ☐ Erectile dysfunction
- ☐ STD
- ☐ Painful intercourse
- ☐ Painful testicles
- ☐ Painful urination
- ☐ Menopausal

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Heart palpitations
- ☐ Fainting spells
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Left arm pain
- ☐ Ankle swelling
- ☐ Rapid heartbeat
- ☐ Pacemaker
- ☐ Previous heart attack (s)
- ☐ Poor circulation

Gastrointestinal
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ Indigestion / cramping
- ☐ Sensitive to dairy
- ☐ IBS
- ☐ Nausea / vomiting
- ☐ Blood in stool
- ☐ Celiac / Gluten sensitivity
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Painful bowel movements
- ☐ Colitis
- ☐ Constipation
- ☐ Gassy / belching

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ COPD
- ☐ Chronic bronchitis
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Coughing blood

Neurological
- ☐ Disorder / disease
- ☐ Weakness in arms / legs
- ☐ Poor balance / falling
- ☐ Pins and needles
- ☐ Numbness
- ☐ Change in senses
- ☐ Fainting spells
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Tremors / tics
- ☐ Sciatica / pinched nerve
- ☐ Carpal tunnel

Endocrine
- ☐ Diabetes
- ☐ Hyperglycemic
- ☐ Hypoglycemic
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Unusual weight change
- ☐ Hot flashes
- ☐ Unusual fatigue
- ☐ Frequent urination
- ☐ Excessive thirst

Musculoskeletal
- ☐ Numbness
- ☐ Joint pain
- ☐ Spinal pain
- ☐ Scoliosis
- ☐ Disc problems
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Arm / elbow / hand pain
- ☐ Hip / knee / ankle pain
- ☐ Sciatica
- ☐ Foot pain
- ☐ Shoulder pain

Psychiatric
- ☐ Alcoholism
- ☐ Anger problems
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Sex abuse victim
- ☐ Drug addiction
- ☐ Suicidal thoughts
- ☐ Body image problems
- ☐ Paranoia
- ☐ Personality disorder

Skin
- ☐ Rash / itch / boils
- ☐ Moles that have changed
- ☐ Eczema / dermatitis
- ☐ Psoriasis
- ☐ Allergies
- ☐ Change in hair / nails
- ☐ Cancer

Hematologic / Lymphatic
- ☐ Anemic
- ☐ Hemophilia
- ☐ Blood transfusions
- ☐ Blood thinners
- ☐ Lumps / bumps / masses
- ☐ Swollen lymph nodes

Allergic / Immunologic
- ☐ Food allergies
- ☐ Swollen lymph nodes
- ☐ Animal allergies
- ☐ Auto immune disorders

Infectious Disease
- ☐ TB
- ☐ HIV
- ☐ Hepatitis
- ☐ Other

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PATIENT INTAKE

7 – PATIENT HISTORY Name:

What are your complaints, be as detailed as possible, how & when it began (if you are here for fertility acupuncture only, skip to the bottom half of this page & then fill out the fertility addendum)**:**

____

____

____

____

Circle the grade of your pain (No pain) 0 ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10 (Worst pain)

List DAILY LIFE THINGS this has interfered with (work, home, exercise, sleep, etc)

____

List all TREATMENTS & TESTS you have done for this (doctors, rehab, X-rays, MRI, etc)

____

FAMILY DOCTOR ____________________ PAST CHIROPRACTOR ____________________

SURGERIES ____

IMPORTANT PAST MEDICAL HISTORY / DISEASE / ILLNESS ________________________________

____

____

MEDICATIONS & SUPPLEMENTS ____

____________________________ MEDICATION ALLERGIES __________________ ☐ None

FAMILY MEDICAL HISTORY (cancer, diabetes, heart disease, neurological, arthritis, spinal surgery, disc disease, etc)

____

Do you have **metal implants** in your body? ☐ Yes ☐ No If YES, list __________________________

IMPORTANT: Do you have a pacemaker or defibrillator? ☐ **Yes** ☐ **No**

LIST ANY OTHER IMPORTANT INFORMATION ______________________________________

____

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