PATIENT MEDICAL HISTORY INTAKE FORM

Patient Name: ______________________________ **Date:** ____________________

Date of Birth: ______________________________

Primary Health Concerns: ______________________________

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Secondary Health Concerns: ______________________________

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Date of onset of symptoms: ______________________________

Pain from this condition is: ☐ minimal ☐ moderate ☐ slight ☐ severe

Have you had this condition in the past? ______________

What makes it better? ______________________________

What makes it worse? ______________________________

Is your condition: ☐ getting worse ☐ comes and goes ☐ constant ☐ don't know

Medications you are currently taking: ______________

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List surgeries/procedures: ______________________________

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Have you been injured in an accident? Yes No

If yes, please describe: ______________________________

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Date of last physical exam: ______________________________

Medical History: (Please check box if you have ever had the following)

- ☐ arthritis
- ☐ asthma
- ☐ bronchitis
- ☐ pneumonia
- ☐ allergies
- ☐ anemia
- ☐ heart problems
- ☐ chronic pain
- ☐ migraine headache
- ☐ eye disorder
- ☐ cancer
- ☐ diabetes
- ☐ epilepsy
- ☐ stroke
- ☐ kidney or bladder problems
- ☐ gallstones
- ☐ ulcers
- ☐ gastric reflex
- ☐ eating disorder
- ☐ high blood pressure
- ☐ chronic fatigue
- ☐ hepatitis
- ☐ alcoholism
- ☐ substance abuse
- ☐ jaundice
- ☐ female reproductive disorders
- ☐ sudden weight loss
- ☐ sudden weight gain

Family History: (Please list any major medical conditions that your parents have or had that you know of)

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Are your currently receiving care from:

- ☐ chiropractor
- ☐ medical specialist
- ☐ physical therapist
- ☐ massage therapist
- ☐ nutritionist
- ☐ therapist

Have you had acupuncture before? Yes No

If yes, for what condition? ______________________________

Do you use any of the following?

- ☐ Alcohol Amount/Wk ______________________
- ☐ Tobacco Amount/Wk ______________________
- ☐ Coffee Cups/Day ______________________
- ☐ Carbonated sugar drinks (Pepsi, Coke, etc.) Servings/Day ______________________
- ☐ Foods labeled "Diet"
- ☐ Processed Foods

How many glasses of water do you drink per day? __________

What exercise do you do on a regular basis?

- ☐ walking
- ☐ jogging
- ☐ bicycle
- ☐ hiking
- ☐ rowing/kayaking
- ☐ sports
- ☐ gym workout/training
- ☐ exercise classes
- ☐ yoga
- ☐ Pilates/Core/Barre
- ☐ dance
- ☐ other ______________

Please complete reverse ▶

PATIENT SYMPTOM SURVEY

Patient Name: ______________________________ Date: ______________

GENERAL
PAST NOW
- ☐ ☐ fatigue
- ☐ ☐ sleep problems
- ☐ ☐ swollen glands
- ☐ ☐ hot/cold intolerance
- ☐ ☐ frequent headaches
- ☐ ☐ weight loss
- ☐ ☐ weight gain
- ☐ ☐ fever or chills
- ☐ ☐ allergies

EMOTIONAL
- ☐ ☐ nervousness
- ☐ ☐ anxiety or worry
- ☐ ☐ frequent crying
- ☐ ☐ irritability
- ☐ ☐ anger
- ☐ ☐ tension
- ☐ ☐ mood swings
- ☐ ☐ fear
- ☐ ☐ restlessness
- ☐ ☐ confusion
- ☐ ☐ depression
- ☐ ☐ suicidal thoughts

NERVOUS SYSTEM
- ☐ ☐ dizziness
- ☐ ☐ fainting
- ☐ ☐ paralysis
- ☐ ☐ tremors
- ☐ ☐ numbness/tingling
- ☐ ☐ convulsions
- ☐ ☐ memory loss
- ☐ ☐ muscle weakness

GASTROINTESTINAL
- ☐ ☐ change in appetite
- ☐ ☐ thirst
- ☐ ☐ nausea
- ☐ ☐ vomiting
- ☐ ☐ diarrhea
- ☐ ☐ constipation
- ☐ ☐ gas
- ☐ ☐ hemorrhoids
- ☐ ☐ belching
- ☐ ☐ heartburn
- ☐ ☐ abdominal pain
- ☐ ☐ bloody/black stools
- ☐ ☐ indigestion

URINARY
- ☐ ☐ painful urination
- ☐ ☐ frequent urination
- ☐ ☐ difficult urination
- ☐ ☐ incontinence
- ☐ ☐ bed wetting
- ☐ ☐ dark urine
- ☐ ☐ frequent infections
- ☐ ☐ prostate problems

REPRODUCTIVE SYSTEM
PAST NOW
- ☐ ☐ painful intercourse
- ☐ ☐ prostate problems
- ☐ ☐ sexual problems
- ☐ ☐ loss of sex drive
- ☐ ☐ genital infections

birth control method: ________

WOMEN ONLY
- ☐ ☐ cramps
- ☐ ☐ PMS
- ☐ ☐ irregular periods
  - Are you pregnant?
  - ☐ Yes ☐ No
  - date of last period ____
  - # pregnancies ________
  - # of miscarriages ______
- ☐ ☐ difficult labor
- ☐ ☐ breast problems

HEAD
- ☐ ☐ headache
  - ☐ ☐ entire head
  - ☐ ☐ back of head
  - ☐ ☐ forehead
  - ☐ ☐ temples
  - ☐ ☐ migraine
- ☐ ☐ head feels heavy
- ☐ ☐ loss of memory
- ☐ ☐ light-headedness
- ☐ ☐ fainting
- ☐ ☐ light bothers eyes
- ☐ ☐ loss of smell
- ☐ ☐ loss of taste
- ☐ ☐ loss of balance
- ☐ ☐ dizziness

EYES, EARS, NOSE, THROAT
- ☐ ☐ eye pain
- ☐ ☐ dry eyes
- ☐ ☐ blurred vision
- ☐ ☐ earache
- ☐ ☐ ear discharge
- ☐ ☐ ringing in ears
- ☐ ☐ hearing loss
- ☐ ☐ nosebleeds
- ☐ ☐ hoarseness
- ☐ ☐ problems swallowing
- ☐ ☐ sore throat
- ☐ ☐ jaw tight or sore
- ☐ ☐ dental problems

NECK
- ☐ ☐ pain in neck
- ☐ ☐ pain with movement
- ☐ ☐ pinched nerve in neck
- ☐ ☐ stiff neck
- ☐ ☐ muscle spasms in neck
- ☐ ☐ arthritis in neck

CHEST
PAST NOW
- ☐ ☐ chest pain
- ☐ ☐ shortness of breath
- ☐ ☐ pain around ribs

MUSCULOSKELETAL
- ☐ ☐ joint swelling
- ☐ ☐ muscle cramps
- ☐ ☐ neck pain
- ☐ ☐ shoulder pain
- ☐ ☐ tennis elbow
- ☐ ☐ arm pain
- ☐ ☐ hand sensations
- ☐ ☐ loss of grip
- ☐ ☐ mid-back pain
- ☐ ☐ rib pain
- ☐ ☐ low back problems
- ☐ ☐ hip pain
- ☐ ☐ foot problems
- ☐ ☐ leg cramps
- ☐ ☐ knee pain
- ☐ ☐ ankle weakness
- ☐ ☐ tingling foot

LOW BACK
- ☐ ☐ low back pain
- ☐ ☐ low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
- ☐ ☐ pinched nerve
- ☐ ☐ slipped disk
- ☐ ☐ muscle spasms
- ☐ ☐ arthritis

MID BACK
- ☐ ☐ mid back pain
- ☐ ☐ pain between shoulder blades
- ☐ ☐ sharp stabbing pain
- ☐ ☐ muscle spasms

SHOULDERS
- ☐ ☐ pain in shoulder joint
- ☐ ☐ pain across shoulders
- ☐ ☐ bursitis (R/L)
- ☐ ☐ arthritis (R/L)
- ☐ ☐ tension in shoulders
- ☐ ☐ pinched nerve
- ☐ ☐ limited range of motion

ARMS & HANDS
PAST NOW
- ☐ ☐ pain in upper arm
- ☐ ☐ pain in forearm
- ☐ ☐ pain in hands
- ☐ ☐ pain in fingers
- ☐ ☐ pinched nerve in arm
- ☐ ☐ pinched nerve in hand
- ☐ ☐ pins & needles in arm
- ☐ ☐ pins & needles in hand
- ☐ ☐ fingers go to sleep
- ☐ ☐ hands cold
- ☐ ☐ swollen joints in fingers
- ☐ ☐ arthritis in fingers
- ☐ ☐ loss of grip strength

HIPS, LEGS & FEET
- ☐ ☐ pain in buttocks (R/L)
- ☐ ☐ pain in hip joint (R/L)
- ☐ ☐ pain down leg (R/L)
- ☐ ☐ pain down both legs
- ☐ ☐ leg cramps
- ☐ ☐ pins & needles in legs
- ☐ ☐ numbness of leg (R/L)
- ☐ ☐ numbness of feet (R/L)
- ☐ ☐ numbness of toes
- ☐ ☐ feet feel cold
- ☐ ☐ cramps in feet (R/L)
- ☐ ☐ swollen ankles (R/L)
- ☐ ☐ swollen feet (R/L)
- ☐ ☐ painful joints in toes
- ☐ ☐ pain in foot (R/L)
- ☐ ☐ pain in knee (R/L)

HEART/LUNG
- ☐ ☐ chest pain
- ☐ ☐ high blood pressure
- ☐ ☐ low blood pressure
- ☐ ☐ persistent cough
- ☐ ☐ hard to breathe
- ☐ ☐ coughing blood
- ☐ ☐ coughing phlegm
- ☐ ☐ irregular heartbeat
- ☐ ☐ varicose veins
- ☐ ☐ ankle swelling

SKIN
- ☐ ☐ easy bruising
- ☐ ☐ dry skin
- ☐ ☐ itching
- ☐ ☐ boils
- ☐ ☐ rashes
- ☐ ☐ excessive sweat
- ☐ ☐ hair changes

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PATIENT SIGNATURE

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