PERSONAL HISTORY

Dear Patient, welcome to our office, this form is designed to help us to get the cause of your current health problem as quickly as possible. The more detailed and accurate you are, the better care we can provide. Your overall health is just as important to us as your current major complaints. No symptom is insignificant. The more you tell us, the more we will be able to help you achieve your health goals.

Date: _____ Email: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Business phone: _____ Birth date: _____

Age: _____ Sex: M F Height: _____ Weight: _____

Business/Employer: _____ Type of work: _____

Check one: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ DP

Spouse's name: _____ No. of children: _____ Emergency Contact: _____ Phone: _____

Referred to this office by: _____ Your Driver's Lic. #: _____

Name and address of nearest relative not living with you: _____

Are you/have you been disabled from work? _____

Current Medications: ☐ Tranquilizers ☐ Pain Killers/Muscle Relaxants ☐ Blood Pressure

☐ Insulin ☐ Aspirin/Similar ☐ Hormones ☐ Other

Specific drug or substance: _____

Natural Remedies: Vitamins/Minerals: _____

Herbs: _____

Homeopathics: _____

CURRENT HEALTH CONDITIONS

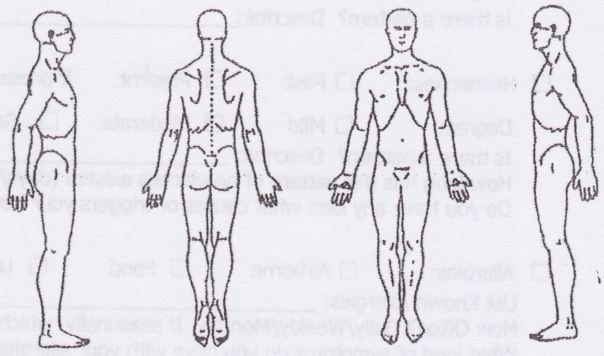
Please fill out this section for your major complaints, start with the complaint you feel is most significant and indicate on the drawing where your pain is located.

1. MAJOR COMPLAINT: _____ Date of onset: _____ ☐ Sudden ☐ Gradual

How bad is your pain or ache? Please circle a number: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Describe your pain or complaint:

1. ◇ Dull ◇ Sharp ◇ Ache ◇ Stabbing
   ◇ Deep ◇ Superficial ◇ Spasm/tension ◇ Numbness
   ◇ Tingling ◇ Burning ◇ Other
2. Radiation: Does the pain go to other parts of the body?
   ◇ Yes ◇ No Where? _____
3. Frequency: ◇ Occasional ◇ Intermittent ◇ Constant
4. How long does the pain last? _____
5. What makes the pain worse?
   ◇ Standing ◇ Sitting ◇ Bending ◇ Twisting
   ◇ Walking ◇ Lifting ◇ Sleeping ◇ Heat
   ◇ Cold ◇ Stooping ◇ Sex ◇ Other
6. What makes the pain better?
   ◇ Sitting ◇ Standing ◇ Rest ◇ Heat ◇ Cold
   ◇ Aspirin/medication ◇ Other _____
7. Other problems related to your main complaint: _____
8. What treatment have you received for this condition? _____



Dr.'s Notes- Please do not write in this space

_____

_____

Check any of the following conditions you have experienced other than your current major complaints:

MUSCULO-SKELETAL

	Past	Present	Mild	Moderate	Severe
Low back pain	◇	◇	◇	◇	◇
Pain between shoulders	◇	◇	◇	◇	◇
Neck	◇	◇	◇	◇	◇
Arm pain/numbness/weakness	◇	◇	◇	◇	◇
Joint pain/stiffness	◇	◇	◇	◇	◇
Walking problems	◇	◇	◇	◇	◇
Muscle cramps	◇	◇	◇	◇	◇

	Past	Present	Mild	Moderate	Severe
Leg pain/numbness/weakness	◇	◇	◇	◇	◇
General stiffness	◇	◇	◇	◇	◇
Fractures	◇	◇	◇	◇	◇
Foot/ankle problems	◇	◇	◇	◇	◇
Difficult chewing/clicking jaw	◇	◇	◇	◇	◇
Shoulder problems	◇	◇	◇	◇	◇
Knee problems	◇	◇	◇	◇	◇
Hip problems	◇	◇	◇	◇	◇

PAST HEALTH HISTORY

List all surgery with dates: _____

_____

Any major or minor accidents (include "fender benders"), and falls (gymnastics, horse, etc.): _____

Hospitalization (other than above): _____

Previous Acupuncture care: ☐ Yes ☐ No Dr.'s Name _____

Date of last visit: _____ Condition treated: _____ X-Rays taken: _____

Last medical physical: _____ Most recent blood work: _____

DISEASE

Check any of the following diseases you have had:

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ Venereal Disease	☐ Genital Warts
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy	☐ Asthma	☐ Herpes
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Anemia	☐ Heart Disease
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy/Seizures	☐ Thyroid	☐ Measles
☐ Whooping Cough	☐ Cancer	☐ Mental Disorder	☐ Eczema	☐ German Measles/Rubella

Have you been treated for any other condition not covered in this questionnaire? (please describe) _____

_____

When? _____

SLEEP HABITS: Average hours per night? _____ Is it quality sleep? ☐ Yes ☐ No

Do you awake refreshed? ☐ Yes ☐ No Do you awake tired and exhausted? ☐ Yes ☐ No

GENERAL

☐ Fatigue: ☐ Past ☐ Present If present: ☐ Mild ☐ Moderate ☐ Severe Daily? ☐ Yes ☐ No

Is there a pattern? Describe: _____

☐ Headaches: ☐ Past ☐ Present If present, how frequent: ☐ Daily ☐ Weekly ☐ Monthly

Degree: ☐ Mild ☐ Moderate ☐ Severe Location of pain: _____

Is there a pattern? Describe: _____

How long has this pattern of headaches existed (days/weeks/months/years)? _____

Do you have any idea what causes or triggers your headaches? _____

☐ Allergies: ☐ Airborne ☐ Food ☐ Unknown

List Known Allergies: _____

How Often? Daily/Weekly/Monthly If seasonally, which seasons? _____

What kind of symptoms do you have with your allergies? _____

☐ Loss of Sleep: ☐ Past ☐ Present If present, how frequently does this occur? _____

Do you have difficulty falling asleep or staying asleep? (circle one or both) ☐ Yes ☐ No

What other factors do you think cause or influence this condition? _____