Paige Chiropractic and Acupuncture PLLC

Chiropractic and/or Acupuncture Initial Intake Form

Present Health Concerns

Chief Complaint:_____**Date of Onset:**_____
Did you go to the HOSPITAL/EMERGENCY ROOM for THIS CONDITION?
❒ No if no, skip to the next bold question
❒ Yes if yes, please continue
Name of facility:_____Location:_____
Were you taken by ambulance? ❒ Yes ❒ No
Is your condition due to an accident? ❒ Yes ❒ No Date:_____
Type of accident: ❒ Auto ❒ Work ❒ Home ❒ Other _____
Did you go immediately to the medical facility after the accident? ❒ Yes ❒ No
Were X-rays taken? ❒ Yes ❒ No What area of the body? _____
What was the diagnosis?_____What was the treatment?_____
When/how did your present health concern start?
❒ Immediately after a specific incident ❒ After multiple incidents
❒ Gradually, over time ❒ No specific reason
Since the problem began, the pain has:
❒ Increased ❒ Decreased ❒ Not changed
How often are the complaints present?
❒ Constantly (100%-76% of the time) ❒ Frequently (75%-51% of the time)
❒ Occasionally (50%-26% of the time) ❒ Intermittent (25%-0% of the time)
What describes the nature of your symptoms?
❒ Sharp ❒ Dull ache ❒ Numb ❒ Shooting
❒ Burning ❒ Tingling ❒ Stabbing
Indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)
❒ 0 None ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5
❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 Unbearable
Is the condition worse during certain times of the day? ❒ Yes ❒ No _____
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Does it interfere with your:
❒ Work ❒ Sleep ❒ Daily routine ❒ Recreation
Have you had similar symptoms in the past? ❒ Yes ❒ No
Have you been treated for this condition or a similar condition before? ❒ Yes ❒ No
If yes, what type of treatment, and by whom? _____
Have you ever been to a (chiropractor/acupuncturist) before? ❒ Yes ❒ No
In general, would you say your overall health right now is…
❒ Excellent ❒ Very good ❒ Good ❒ Fair ❒ Poor

Please list all MEDICATIONS that you are currently taking or have used in the past two months:

1._____ 4._____
2._____ 5._____
3._____ 6._____

Please list any VITAMINS, MINERALS, HERBS, OR HOMEOPATHIC REMEDIES that you are presently taking:

1._____ 4._____
2._____ 5._____
3._____ 6._____

Please list ALLERGIES that you have (drugs, food, pollen, paint, etc.):

_____

Comments

Please let us know of any other concerns you would like to address:

_____
_____

Health History

Past Medical History: Please list past injuries, broken bones, surgeries, and hospitalizations, with approximate dates.

_____
_____

Personal History:

❒ Tobacco packs/day_____
❒ Alcohol drinks/week_____
❒ Coffee/tea/cola cups/day_____
❒ Recreational drugs times/week_____

Work Activity:

❒ Sitting % of time_____
❒ Standing % of time_____
❒ Light labor % of time_____
❒ Heavy labor % of time_____

Exercise: Do you exercise regularly? ❒ Yes ❒ No

If Yes, describe and tell how often:_____

Family History:

	Cancer	Diabetes	Heart Disease	Arthritis	Other_____
Father's side	❒	❒	❒	❒	❒
Mother's side	❒	❒	❒	❒	❒

Have you been diagnosed with any of the above conditions?_____

CHIROPRACTIC ONLY

Please check ALL of the following that apply to you:

❒ Headache ❒ Neck pain ❒ Neck stiffness
❒ Jaw pain ❒ Shoulder pain ❒ Hand pain
❒ Hip pain ❒ Leg pain ❒ Foot pain
❒ Numbness in fingers ❒ Numbness in toes ❒ Pins/needles in arms
❒ Pins/needles in legs ❒ Stiffness of joints ❒ Joint swelling
❒ Fainting ❒ Dizziness ❒ Loss of consciousness
❒ Seizures ❒ Nausea ❒ Balance problems
❒ Shortness of breath ❒ Chest pains ❒ Loss of appetite
❒ Unexplainable weight loss ❒ Night sweats ❒ Pain worse at night
❒ Sleep problems ❒ Excessive thirst ❒ Frequent urination
❒ Constipation ❒ Diarrhea ❒ Colitis/IBS
❒ Heartburn ❒ Ulcer ❒ Asthma
❒ Respiratory problems ❒ Chronic cough/bronchitis ❒ Difficulty swallowing
❒ Loss of bladder control ❒ Loss of bowel control ❒ High blood pressure
❒ Kidney stones ❒ Arthritis ❒ Diabetes
❒ Cancer_____ ❒ Stroke: date_____ ❒ Heart attack: date_____
❒ Bypass ❒ Abdominal aortic aneurysm ❒ Pacemaker
❒ Metal implants ❒ Other surgical procedures_____

ACUPUNCTURE ONLY

General:

❒ Poor appetite ❒ Fevers/Chills ❒ Tremors ❒ Poor sleeping
❒ Heavy appetite ❒ Sweat easily ❒ Localized weakness ❒ Heavy sleeping
❒ Night sweats ❒ Cravings ❒ Fatigue ❒ Sudden energy drop
❒ Dizziness ❒ Peculiar tastes ❒ Thirst ❒ Weight loss/gain
❒ Changes in appetite ❒ Bleed/bruise easily ❒ Dream disturbed sleep

Skin/Hair:

❒ Rashes/Hives ❒ Ulcerations ❒ Eczema/Psoriasis ❒ Recent moles
❒ Itching ❒ Dry skin ❒ Fungal infections ❒ Pimples/Acne
❒ Loss of hair ❒ Dandruff ❒ Changes in hair of skin texture
❒ Other skin/hair concerns:_____

Head, Eyes, Ears, Nose, and Throat:

❒ Concussions ❒ Glasses/Contacts ❒ Spots in front of eyes ❒ Eye strain/pain
❒ Red eyes ❒ Dry eyes ❒ Itchy eyes ❒ Excessive tearing
❒ Poor/blurry vision ❒ Night blindness ❒ Cataracts/Glaucoma ❒ Poor hearing
❒ Earaches/Infections ❒ Ringing in the ears ❒ Swollen glands ❒ Sinus problems
❒ Post nasal drip ❒ Excessive phlegm ❒ Recurrent sore throats ❒ Nose bleeds
❒ Dry mouth ❒ Excessive saliva ❒ Sores on lips/tongue ❒ Teeth problems
❒ Gum problems ❒ TMJ disorder ❒ Grinding teeth ❒ Headaches
❒ Other head and neck concerns:_____

Cardiovascular:

❒ High blood pressure ❒ Low blood pressure ❒ Irregular heartbeat ❒ Chest pains
❒ Palpitations ❒ Fainting ❒ Cold hands/feet ❒ Blood clots
❒ Phlebitis ❒ Swelling of hands ❒ Swelling of feet
❒ Other heart or blood vessel concerns:_____

Respiratory:

❒ Cough ❒ Coughing blood ❒ Wheezing ❒ Asthma
❒ Bronchitis ❒ Pneumonia ❒ Pain with deep breath ❒ Tight chest
❒ Shortness of breath ❒ Production of phlegm
❒ Other lung related concerns:_____

Gastro-Intestinal:

❒ Nausea ❒ Vomiting ❒ Diarrhea ❒ Constipation
❒ Gas/Bloating ❒ Hiccups ❒ Belching ❒ Bad breath
❒ Blood in the stools ❒ Black stools ❒ Mucus in the stools ❒ Abdominal pain
❒ Acid regurgitation ❒ Itchy anus ❒ Burning anus ❒ Hemorrhoids
❒ Other gastrointestinal concerns:_____

Genito-Urinary:

❒ Pain on urination ❒ Frequent urination ❒ Blood in urine
❒ Urgency to urinate ❒ Unable to hold urine ❒ Decrease in flow
❒ Bedwetting ❒ Kidney stones ❒ Impotency
❒ Increased libido ❒ Decreased libido ❒ Premature ejaculation
❒ Nocturnal emissions ❒ Sores on genitals ❒ Frequent UTI's
❒ Decrease in flow ❒ Chronic yeast infections
❒ Other concerns with genitals and/or urinary system:_____

Musculoskeletal:

❒ Neck pain ❒ Upper back pain ❒ Lower back pain ❒ Hand/wrist pain
❒ Muscle pain ❒ Muscle weakness ❒ Cramps/spasms ❒ Shoulder pain
❒ Hip pain ❒ Foot/ankle pain ❒ Muscle pains ❒ Knee pain
❒ General joint pain/stiffness ❒ Joint with limited range of motion:_____
❒ Other muscle, joint, or bone concerns:_____

Neuropsychological:

❒ Seizures ❒ Loss of balance ❒ Areas of numbness ❒ Tics
❒ Memory loss ❒ Concussion ❒ Lack of coordination ❒ Depression
❒ Anxiety ❒ Irritability ❒ Easily stressed ❒ Easy to anger
❒ History of emotional/physical abuse
Have you ever been treated for emotional problems?_____
Have you ever considered or attempted suicide?_____
❒ Other neurological or psychological concerns:_____

Gynecology:
Age of first menses:_____ If no longer, approximate date ceased:_____
First day of last menses:_____ Length between menses:_____days
Duration of period:_____days
❒ Unusual flow (❒ heavy ❒ light) ❒ Clots in flow ❒ Vaginal dryness
❒ Painful periods ❒ Vaginal discharge ❒ Vaginal sores
❒ Irregular periods ❒ Vaginal odor ❒ Hot flashes
❒ Breast lumps/soreness
Changes in body or psyche prior to menstruation ("PMS"):_____
Date of last PAP:_____ Results were: ? Normal ? Abnormal ? Unsure
If you use birth control, what type and for how long?_____
Have you ever used hormonal methods for contraception or period regulation (the pill, Depo-Provera, etc.)?_____
Other gynecological concerns:_____

Pregnancy history:
Number of pregnancies_____ Births_____ Miscarriages_____ Abortions_____
Any complications at birth? Explain:_____
_____
Other pregnancy related concerns:_____

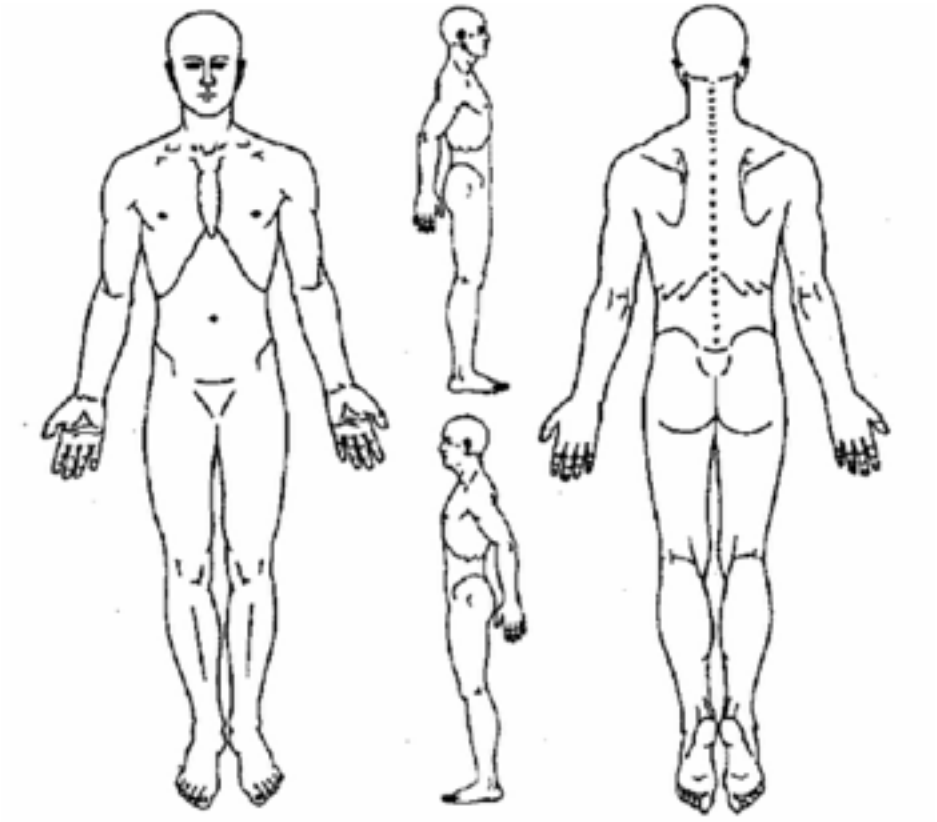
Goals:
What results do you hope to obtain in our office? (Check all that apply)
_____Relief Care: Relief from pain and symptoms to be more comfortable
_____Corrective Care: Go beyond relief from pain and correct the problem at its source
_____Wellness Care: Maintain the care you've received. Focus on your health, wellness, and prevention.

Please rate your level of commitment to achieving your wellness goals:
1 2 3 4 5 6 7 8 9 10

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



NAME _____ DATE _____

No Pain |——————————————————————————————| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature