Name_____ **Date**_____

What brings you in today?

_____
_____
_____
_____

What makes your condition worse?

_____

What have you tried to get relief?

What works: _____

What does not work: _____

- ☐ Medications
- ☐ Vitamins / Minerals/ Herbs
- ☐ Prior acupuncture?
  - o No
  - o Yes, describe treatment

_____

- ☐ Prior chiropractic?
  - o No
  - o Yes, describe treatment

_____

- ☐ Hospitalizations
  - o Dates: _____
- ☐ Surgery
  - o Dates: _____
- ☐ Trauma, include dates
  - o Accidents: _____
  - o Falls: _____
  - o Injuries: _____
- ☐ Head Trauma
- ☐ Headache / Migraine
- ☐ Dizziness
- ☐ Depression
- ☐ Nervousness
- ☐ Difficulty Sleeping / Fatigue
- ☐ Chest pain
- ☐ Heart conditions
- ☐ High blood pressure
- ☐ Pain or stiffness
  - o Neck
  - o Shoulder
  - o Upper/ Mid / Lower back
  - o Hip
  - o Leg
  - o Cramps
  - o Numbness / tingling
- ☐ Sinus problems / Breathing Problems
- ☐ Night Sweats
- ☐ Unexplained weight loss in past 6 months
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach
- ☐ Kidney
- ☐ Bladder
- ☐ Liver
- ☐ Colon
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Thyroid Ulcers
- ☐ Blood disorders: _____
- ☐ Alcohol, # of drinks/week: _____
- ☐ Smoke, # per day: _____
- ☐ Fast food, # of meals/ week: _____

Height: ____ Weight: ____

Date of last physical & bloodwork: _____