Today's Date _____________ Social Security #________________
Last Name ______________________________Date___________
First Name _________________________ Initial________________
Address ____
City ________ State _____ Zip__________

Email Address @ home ___________________________________
Email Address @ work ____________________________________
Birthdate __/__/__
Marital Status: Married/Divorced/Single

Age: ______ Gender: M/F Ht.: __ Feet __ Inches Wt.:____

Phone @ work______________ Phone @ home_______________

Cell Phone ____________________

Emergency Contact Name and Phone_________________________

How did you hear about our office? _________________________

Have you been to our website: www.BigCreekChiro.com Y/N

Have you been treated by Acupuncture before? Y/N
Date of last visit______________

Have you been treated with Chinese Herbal Medicine before? Y/N
Which Chinese formula(s) you have taken in the past?

____

Reason for visit today? ___________________________________
How long have you had this condition? ________________________
Is it getting worse? _______________________________________

Does it bother your: Sleep, Work, Social, Exercise, Travel,
Other: ____
What seemed to be the initial cause? _________________________
What seems to make it better? ______________________________

What makes it worse? ____

Are you under the care of a physician now? Y/N
Who is your physician? _______________________________________
What was the physicians' diagnosis? ___________________________
____

Other therapies tried or using concurrently: **Please circle**.

Chiropractic, Massage, Osteopathic Manipulation, Yoga, Meditation, Nutrition, Reiki, Healing Touch, Naturopathy
Other (what?)____

If you are currently taking prescription drugs, please list below:

Drug Name/ Dosage	For What Purpose/ Condition	Began Taking/ Stopped Taking	Who Prescribed it to you	Reactions
1				
2				
3				
4				
5				
6				

use back side of paper if you need more space

If you are currently taking supplements/vitamins/herbs, please list below:

Name of Item/brand	For what purpose/Condition	Began Taking / Stopped Taking	Who suggested you take it	Reactions
1				
2				
3				
4				
5				
6				

7				

use back side of paper if you need more space

Yes, I have an infectious disease.
Please describe: ____

Family Medical History: **Please Circle**.

AIDS	**Blood Pressure High / Low**	**Asthma**	**Mental Illness**	**Alcoholism**
Allergies	**Cancer**	**Diabetes Type 1 or 2**	**Heart Disease**	**Seizures**
Stroke	**Thyroid Disease**			

All surgeries or trauma, please list below: (include approx. dates)

Personal Medical History: Please Circle.

Alcoholism	**Asthma**	**Allergies**	**Arteriosclerosis**	**Cancer**
Chicken Pox	**Endocrine Disorder**	**Epilepsy**	**Goiter**	**Gout**
Heart Disease	**Herpes/ What type?**	**Chronic Childhood Illness**	**Birth Trauma (Yours)**	**Measles**
Hepatitis/ Treated How?	**Thyroid Disease**	**Tuberculosis**	**Unexplained Rashes**	**Eczema**
Diabetes Type 1 or 2	**Multiple Sclerosis**	**High Blood Pressure**	**Psoriasis**	**Mumps**
Polio	**Scarlet Fever**	**Typhoid Fever**	**Pacemaker**	**Pleurisy**

Rheumatic Fever	Ulcers	Venereal Disease	Whooping Cough	Other:

Current Symptoms: Please Circle.

Diarrhea	Headaches	Anxiety	Breathing Difficulties	Depression
Chest Pain	Chills	Breathing Difficulties	Excess Thirst	Fever
Fatigue	Lack of Thirst	Indigestion	Dizziness	Constipation
Jaw /Teeth Problems	Impotence	Infertility	Lack of Sweating	Menstrual Disorders
Ear Pain	Muscular Pain	Joint Dysfunction/Pain	Premenstrual Syndrome	Menopausal Problems
Overly Emotional	Night Sweating	Nervousness	Sinus Pain/problems	Skin Disorders
Throat Pain/ Problems	High/Low Blood Pressure	Spontaneous Sweating	Insomnia	Weight Loss
Weight Gain	Urination Difficulties	Vision Problems	Other:	Other:

Life Style (Please circle if any of the following apply)

Live Alone	Live with Spouse	Live with Significant Other	Live with Roommate(s)	Live with Parents
Live with Children	Enjoy your work	Enjoy your home	Enjoy your social life	Work 9-5
Work2nd or 3rd Shift	Work Inconsistent Hours	Enjoy Hobbies	Manage own Business	Religious
Spiritual Connection	Unemployed	Full / Part time Student	Have Family Support	Exercise Seldom
Exercise Occasionally	Exercise often 5-6x/Week)	Have Financial Support	Other:	Other:

Diet and Personal Habits: Please Circle.

Currently Use Tobacco	Currently Use Alcohol	Former Tobacco Use	Recreational Drug Use	Vegan Diet/ Began? ____
# of Cigarettes/ day _______	# of drinks per week _________	Year quit tobacco use ___________	# of Uses Per Week __________	Vegetarian Diet Began? ________
Eat Fried Foods/ Daily / Weekly	Eat Sweets Daily/ Weekly	Eat Dairy Daily/ Weekly	Eat Red Meat Daily/ Weekly	Raw Diet? Began? ________
Underweight for Height?	Normal Weight for Height	Overweight for Height	Other:	

Additional information about yourself you would like us to know:

____

____

____

Head/ Ears/ Eyes/ Nose/ Throat: Please Circle.

Glasses	Night Blindness	Eye Strain	Eye Pain	Red Eyes
Itchy Eyes	Spots in Eyes	Spots in Vision	Blurred Vision	Glaucoma
Cataracts	Nosebleeds	Heaviness of head	Ear Ringing	Hearing Loss
Ear Aches	Headaches	Migraines	Cluster Headaches	Concussions
Throat Drainage	Throat Tickle	Post Nasal Drip	Sore Throat	Swollen Glands
Lump in	Enlarge	Teeth	Numerous	Teeth

Throat	Thyroid	Removed	Cavities	Grinding
TMJ	Gum Problems	Lip Mouth Tongue – Sores	Excessive Saliva	Facial Pain
Facial Numbness	Sinus Problems	Sinus Drainage	Poor Vision	Dry Mouth
Excessive Saliva	Excess Phlegm / Color _______	Enlarged Thyroid	Concussions	

Respiratory: Please Circle.

Difficulty Breathing	Shortness of Breath	Chronic Cough	Acute Cough	Tightness in Chest
Asthma	Phlegm / Congestion	Wheezing	Pneumonia	Pleurisy
Rattling Sound with Breath	Can't Sleep Laying Down	Wet Cough	Thick or Thin Cough	Color of Phlegm
Coughing Blood	Other:	Other:	Other:	Other:

Cardiovascular: Please Circle.

High Blood Pressure	Chest Pain	Palpitation	Slow Heart Rate	Blood Clots
Rapid Heart Rate	Edema (Swelling in Body)	Pacemaker	Low Blood Pressure	Fainting
Irregular Heart Beat	Difficulty Breathing	Phlebitis	Other:	Other:

Gastrointestinal: Please Circle.

Nausea	Vomiting	Acid Regurgitation	Acid Reflux	Gas/ Flatulence
Hemorrhoids	Rectal Pain/Itching	Diarrhea	Constipation	Use Laxatives # day_____ # Week____
Use Antacids # Day _______	Hiccups / Frequently	Bloating	Dark Colored Stool	Light Colored

# Week _____				Stool
Mucus in Stool	Colored Stool: Light	Use Fiber Daily or often	Use Digestive Enzymes	Fissures
Bad Breath	Intestinal Pain	Bowl Movement 1x day	Bowl Movement 2-3x/day	Vomiting
Bloody Stools	Burning Anus	Anal Fissures	Other:	Other:

Genito-Urinary: Please Circle.

Pain with urination	Frequent Urination	Incomplete Urination	Urgent Urination	Increased Libido
Kidney Stones	Bed Wetting	Wake To Urinate	Frequent UTI'S	Sexually Trans. Disease
Blood in Urine	Decreased Libido (men)	Impotence	Premature Ejaculation	Nocturnal Emissions
Blood in Urine	Dribbling	Unable to hold Urine		

Male Fertility: Please Circle / Answer.

# Years Trying_______	Undescended Testes	Urologic Surgeries	Varicocele	Penile Discharge
Nocturnal Emissions	Sperm Motility Results	Sperm Morphology Results	Sperm Count Results	Other:

Musculo-Skeletal: Please Circle.

Muscle Weakness	Muscle Cramps	Muscle Spasms	Joint Pain	Joint Instability
Chronic (Long Term) Pain	Acute (Short Term Pain)	Pain Injuries	Muscle Atrophy	Falls
Limited Range	Arthritis	General	Upper/Mid-	Lower Back

of Motion		Aches	Back	
Neck/Shoulder Pain	Rib Pain	Limited use of Muscle	Other:	Other:

Neurological: Please Circle.

Fainting/Syncop e	Drowsiness	Tremor	Stroke	CVA/TIA
Dizziness	Loss of Balance	Convulsions	Seizures	Vertigo
Poor Memory	Paralysis	Numbness	Tics (Where?)____	Eye Twitching
Considered Suicide?	Attempted Suicide?	Other:	Other:	

Neurophysiological: Please Circle.

Depression	Irritable	Easily Stressed	Easily Frustrated	Worry Easily/Anxious
Unresolved Grief	Frightened Easily	Numbness	Abuse Survivor	Receiving Counseling
Depression	Poor Memory	Other:	Other:	

Skin and Hair: Please Circle.

Rashes	Psoriasis	Hair Loss	Hives	Ulcerations
Eczema	Fungal Infection(s) Where? ______________	Acne	Itching	Dandruff
Premature Graying	Hair Changes	Hair Breaking	Thin/Slow Growing Nails	Skin Changes
Other:	Other:			

Vitality and Immune System: Please Circle.

Frequent Colds	Frequent Flu	Less Ability to Adapt	Chronic Mental Cloudiness	Low Energy Lethargic
Slow Wound Healing	Tender/Achy All Over	Prefer Cold Drinks	Prefer Warm/hot Drinks	Recent Weight Loss/Gain
Poor Sleep	Heavy Sleep	Dream Disturbed	Sleep Fatigue	Lack of Strength
Bodily Heaviness in AM	Cold Hands and / or Feet	Poor Circulation	Fever within last 24 hours	Chills Within last 23 hours
Night Sweats	Sweat Easily	Occupational Hazards	Other:	Other:

Gynecology: Please Circle.

Pregnant Y/N	Week #____ in pregnancy	Could Be Pregnant ___	#__________ Pregnancies	#_______ Miscarries
#________ Abortions	# _______ Pre-Mature Births	Use Birth Control Pills Y/N	Use Birth Control (Other)	Use No Contraceptives
Use HRT	Menopausal	# ___ of D & C's	#____ of Live Births	Age at Menopause
Peri-Menopausal	Decreased Libido	Increased Libido	PMS	Pain Before Menses
Pain During Menses	Headaches Before Menses	Headaches during Menses	Headaches After Menses	Bone Density Changes
Fibrocystic Breasts	Breast Lumps	Breast Tenderness	Mastectomy	Lumpectomy
Hysterectomy	Excess Vaginal Discharge	Vaginal Color	Natural Ovulation Day___	Constipated before menses
Loose BM's during period	Vaginal Dryness	Vaginal Itching	Vaginal Pain	Bleed Between Cycles
Painful Periods	Irregular Cycles	Vaginal Sores	Abnormal PAP	Date of Last PAP _______
Acne before	Acne during	Low Back	Spotting	Blood Clots

Period	Period	Pain with /PMS	between cycles	
Heavy Bleeding	Regular Self Breast Exams	Age of Menarch __________	Age of Menopause ___________	Date of last Mammogram ____________
Pads/Tampons/ Diva Cup	Sexual Energy Low	Sexual Energy Normal	Sexual Energy High	Douche Regularly
Vaginal Lubricants Uses	Excessive Facial Hair	Under 20% Ideal Body Weight	Over20% Ideal Body Weight	Mother was exposed to DES During Pregnancy
Taking Steroids Currently	Nipple Discharge	Excessive Oily Skin	Stressful Occupation	Exposed to Environmental Toxins
Other:	Other:			

How long have you been trying to conceive?
____
Fertility treatments Y/N
When____
Where____
_
Whom____
Treatment Types____
Taking medicine to ovulate Y/N
Medication _____________________________**Length**________________________
Medical examination of fallopian tubes Y/N
Results____
Tubal Operations Y/N
When____
Results____
Hormone Laboratory Tests Y/N When____________________________________
Results____
Trying to conceive with single partner Y/N
Number of years married or living together_______________________________
Partner received a fertility workup Y/N
Results___________________________
Partner supportive of conceiving Y/N

Taken oral contraceptives Y/N
When ____________________________ Length ________________________
IUD Y/N When __________________________________Length__________
Depo-Provera Y/N When __________________________Length___________
Results of diagnosis relating to infertility_____________________________
____

Check any of the following conditions you currently have or have had in the past.

Cervical Biopsy	Cervical Operation	Endometriosis	Cervical Cauterization	Cervical Conization
Pelvic Adhesions	Venereal Disease	Regular Yeast Infections	Pelvic Abnormalities	Chlamydia Infection
Pelvic Inflammation Disease	Uterine Fibroids	Uerine Polyps	Other:	Other:

Have you taken any medications for gynecological conditions? (Other than contraceptives, ie, Lupron, Chlomid etc.)
RX____
Reasons____
Length____
____

Average Daily Menu: Please Circle.

Low Appetite	High Appetite	Cups of Coffee/Day___	Soft Drinks/Day___	Artificial Sweetener Use Y/N
Sugar	Salty Food	Add Salt to Food	Thirsty for water	# _____ Glasses of water/Day
Morning Meal	Afternoon Meal	Dinner Meal	Snacks	Snacks
Ideal Junk Food ______	Ideal Meal: ___________	Cravings For: ______________	Other:	Other:

Please sign (initial) all forms front and back.

The Acupuncturist will be with you shortly.
We recommend you use the restroom before you are called back to begin your appointment.

Thank you.