Carmel Wellness Center

Acupuncture and Spine Care

Patient Name:_____

Information Taken By_____ Date_____

Family and Personal Medical History (General Health):

Mother's side:_____ Father's side:_____
Do you have a regular exercise program?_____ Please describe:_____
Do you smoke cigarettes?_____ Please describe:_____
Do you have a normal appetite?_____ If not, please describe:_____
What is the color of your urine?_____ Do you have dry mouth?_____
Do you have normal bowel movement?_____
Do you have a history of any of the following?

___Cancer	___Asthma	___Diabetes	___Thyroid disorders
___Allergies	___Heart disease	___HIV	___Addictive disorders
___Seizure	___Hepatitis	___Stroke	___Mental illness

Please indicate for each of the questions below your experience by use of the following code:
1---never had; 2---previously had; 3---presently have

General:

___Fevers	___Chills	___Fatigue	___Localized weakness
___Tremors	___Mania	___Headaches	___Daytime perspiration
___Insomnia	___Weight loss	___Weight gain	___Night perspiration
___Strong thirsty	___Poor balance	___Joint pain	___Emotional changes

Cardiovascular:

___Hypertension	___Dizziness	___Fainting	___Difficulty of breathing
___Hypertension	___Palpitation	___Chest pain	___Irregular heartbeat
___Swelling of hands or feet		___Cold hands or feet	

Respiratory:

___Cough	___Coughing blood	___Bronchitis	___Cough with phlegm
___Shortness of breathe	___Difficulty breathing when lying down		

Gastrointestinal:

___Nausea	___Vomiting	___Ulcers	___Abdominal bloating
___Indigestion	___Belching	___Constipation	___Abdominal pain
___Bad breathe	___Diarrhea	___Hemorrhoids	___Blood in stools

Genitor-Urinary:

___ Blood in urine	___Painful urination	___Urgent Urination	___Frequent urination
___Painful urination	___Stones in urinary system		___Waking up to urinate, how many times?

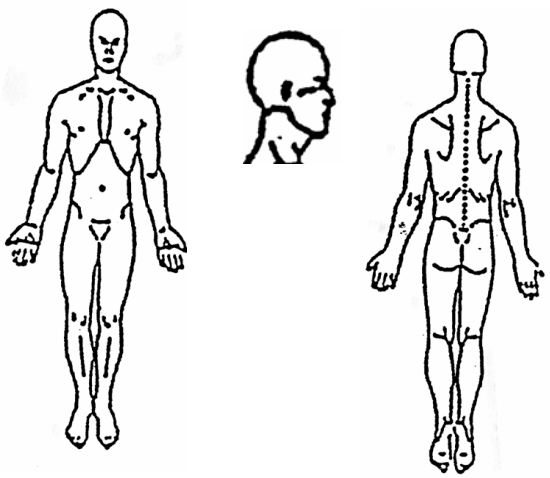
Ear, Nose, Mouth, Throat, and Eyes:

___Ringing in ear	___Poor hearing	___Pain in the ear	___Ear discharges
___Gum bleeding	___Grinding teeth	___Jaw problem	___Sore throat
___Hoarseness	___Facial Pain	___Sinus problem	___Nasal obstruction
___Blurred vision	___Painful eyes	___Night blindness	___Sores on lips or tongue
___Spots in front of eyes		___Difficulty in swallowing	

Musculo-Skeletal System

___Low Back	___Neck problems
___Arm problems	___Leg problems
___Swollen joints	___Painful joints
___Stiff joints	___Pain between shoulders
___Sore muscles	___Weak muscles
___Ruptures	___Broken bones
___Walking problems	

Please mark your areas of pain on the picture to the right.



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Patient Name:_____

Reason for Visit_____
How did it happen?_____
Have you been treated before for this problem? No____ Yes____ When?_____
If yes, by __Physician __Doctor of Chiropractic __Physical Therapist __Osteopath __Other
What did they do and/or recommend? _____
Did you take ___Muscle relaxes ___Pain Killers ___Insulin ___Birth control pill
___Over-the-counter meds ___Other prescription drugs
Medications (List medications you are currently taking) Vitamins/Herbs/Minerals

_____
Date of last: Physical Exam_____ Spinal X-Ray _____ Spinal Exam _____
Blood Test_____ Chest X-Ray _____ Dental X-Ray _____
Urine Test_____ MRI, CT-Scan, Bone Scan _____
How frequent is the condition? Constant____ Daily____ Intermittent ____ Other_____
How long does it last? All Day_____ Few Hours_____ Other_____
Describe the pain. Sharp___ Dull___ Numbness___ Tingling___ Aching___ Burning___ Stabbing___
Other_____
Is there anything you can do to relieve the problem? Yes___ No___
If yes, describe _____
If no, what have you tried to do that has not helped? _____
What makes the problem worse? Standing ___ Sitting___ Lying___ Bending___ Lifting___ Twisting___
Other_____
Have you hand any broken bones? Yes ___ No ___ If yes, please list, and give dates_____
List any significant trauma (auto accident, fall, etc.):_____
Non-job Exercise ____Hrs./Wk Sleep ____Hrs./Night
Do you sleep on your ___Back ___Side ___Stomach
Age of mattress_____ or waterbed_____ Is your bed comfortable? ___no ___yes
What kind of pillow do you use? ___Thick ___Medium ___Thin ___None ___Support
Do you wear ___Heel Lifts ___Shoe Lifts ___Arch Supports ___Orthotics, Describe_____
Check Symptoms You Currently Have or Had in the Past Year

Neck

__Pain in Neck
__Neck stiffness
__Pinched nerve in neck
__Neck feels out of place
__Muscle spasms in neck
__Grinding/popping sounds in neck

Shoulders

__Pain in shoulder joint R L
__Pain across shoulders
__Can't raise arm R L
__Above shoulder level
__Over head
__Tension in shoulders
__Pinched nerve in shoulder R L

Arms & Hands

__Pain in upper arm R L
__Pain in elbow R L
__Pain in forearm R L
__Pain in hand R L
__Pain in fingers R L
__Pins & needles in arm R L
__Pins & needles in fingers R L
__Numbness in arm R L
__Numbness in finger R L
__Weakness of arm R L
__Weakness of hand R L
__Hands Cold R L

Mid Back

__Mid-back Pain
__Mid-back stiffness
__Pain between shoulder blades
__Pain from front to back
__Muscle spasms in mid-back

Hips, Legs & Feet

__Pain in buttocks R L
__Pain in hip joint R L
__Pain down leg R L
__Pain in knee R L
__Pain in ankle R L
__Pain in foot R L
__Weakness of leg R L
__Weakness of knee R L
__Leg cramps R L

Low Back

__Low back stiffens R L
__Low back weakness R L
__Low back pain R L
__Pinched nerve in low back R L
__Low back feels out of place R L
__Muscle spasms in low back R L

Other Symptoms _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.
Patient Signature_____Date_____

Reviewed by Doctor _____Date_____