

# Life Awaits Acupuncture

The following information provided is confidential and is for medical purposes only. It is important you fill it out to the best of your ability. Even if the question seems not to apply to your current condition please fill this form out completely as many things can be connected and will help us better serve you.

Name \_\_\_\_\_ Age \_\_\_\_\_ Date:----- (mm/dd/yr)

DOB: \_\_\_\_\_ (mm/dd/yr) Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender:  male  female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Permission to leave a 'medical' message?  Yes  No

Cell Phone: \_\_\_\_\_ Permission to leave a 'medical' message?  Yes  No

Email for medical/healthcare correspondence: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security: # \_\_\_\_\_

If Yes, was it on the Job? \_\_\_\_\_ Auto Accident? \_\_\_\_\_ Other \_\_\_\_\_

How were you referred to this office \_\_\_\_\_

Please Describe your current problem/complaint that brought you to our office: List them in order of importance. For example #1 is most important, and #5 is least important. *(if your complaint is of pain please also use the diagram on the following page)*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

How long have you had the above condition/s? \_\_\_\_\_

Is it getting worse?  yes,  no

Have you been treated for this condition in the past/present?  yes,  no; If YES, by whom?

\_\_\_\_\_

Have you been diagnosed for this condition?  yes,  no;

Diagnosis: \_\_\_\_\_

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is this condition interfering with  work,  sleep,  routine: others? \_\_\_\_\_

List any other doctors seen for this: \_\_\_\_\_

Have you had similar accidents or injuries before?  yes,  no if yes, explain

Have you received chiropractic treatment or acupuncture treatment previously?

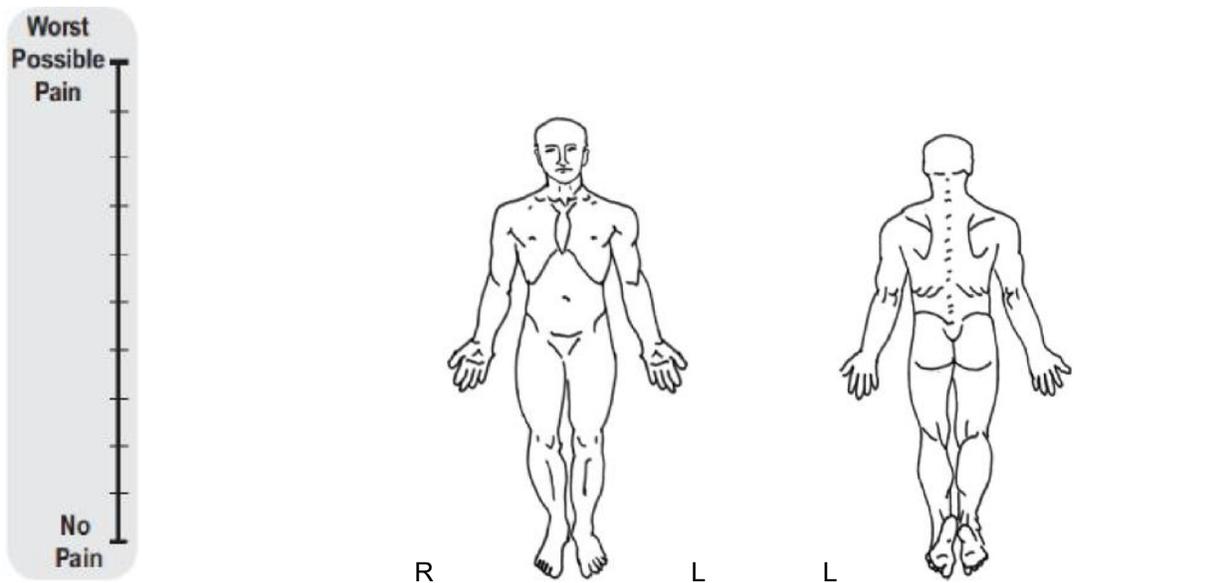
yes ( Chiropractic , Acupuncture )  no

If yes, when, by whom \_\_\_\_\_

**Major goals for the first visit:** Let us know what you would like to accomplish on your first visit.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please circle a number corresponding with to your pain and use "X"s and lines to locate your pain and describe any radiation of pain.





Please rate your daily stress level : none 1 2 3 4 5 6 7 8 9 10 Terrible

Pregnancy: # of pregnancies \_\_\_\_\_ # Birth Children \_\_\_\_\_ N/A \_\_\_\_\_

MOST RECENT VISIT TO A DOCTOR: When was the last time you consulted a doctor, and  
for what reason? \_\_\_\_\_

Date of last complete physical exam: \_\_\_\_\_

Date of most recent lab/blood tests: \_\_\_\_\_