Evolve INTEGRATIVE CHIROPRACTIC & ACUPUNCTURE

INITIAL HEALTH STATUS - ACUPUNCTURE

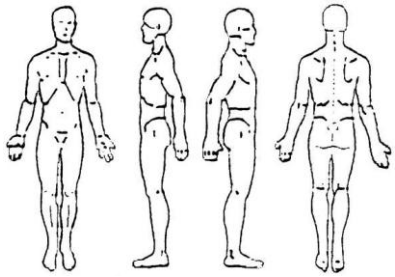
NAME:_____**Date:**_____

Reason for Visit:_____

Date of Injury/Start of Symptoms: _____ Does it affect daily activity?:_____

Were you injured at work?(circle one) Yes No

Was the injury a result of an accident?(circle one) Yes No Automobile/motorcycle accident?(circle one) Yes No



Describe Pain and Location:

MEDICAL HISTORY: Please check if you have any of the following:

( )High blood pressure ( )Diabetes ( )Stroke ( )Heart disease ( )Cancer ( )Respiratory Problems/Asthma

( )Bleeding problems ( )OTHER MEDICAL PROBLEMS (Please list below)

_____

_____

_____

Past hospitalizations/surgeries/injuries and approximate dates.

_____

_____

_____

Allergies (Medication, Food, Seasonal, Latex) (Please List)

_____

_____

Current Medications:

Please List:

FAMILY HISTORY: Please check if any of your relatives ever had any of the following problems - indicate who:

Heart disease:_____ High blood pressure:_____

Diabetes:_____ Stroke:_____

Cancer:_____ Thyroid disease:_____

SOCIAL HISTORY:

Marital status: ☐single ☐married ☐separated ☐divorced ☐widowed

Tobacco use: never quit-when_____ smoker/pack per day_____

Alcohol use: ☐never ☐rarely ☐moderate ☐daily Drug use: ☐never ☐type & frequency_____

REVIEW OF SYSTEMS (Check all that apply to you)

LV/GB

____ Irritability / Anger
____ Depression / Stress
____ Headaches / Migraines
____ Visual problems
____ Red / Dry / Itchy Eyes
____ Gall Stones
____ Dizziness
____ Blurred Vision
____ Feeling of lump in throat
____ Clenching teeth at night
____ Muscle Cramps / Twitching
____ Soft / Brittle Nails
____ Emotional eater

KD/UB

____ Urinary problems
____ Bladder infection
____ Lack of bladder control
____ Weakness / Pain in Low Back
____ Decreased bone density
____ Feel cold easily
____ Low sex drive
____ Excess sexual desire
____ Poor memory
____ Hearing problems
____ Hot Flash / Night Sweats

HT/SI

____ Heart palpitations
____ Chest pain
____ Insomnia / Sleep problems
____ Easily startled
____ Restlessness / Agitation
____ Vivid dreams
____ Lack of joy in life

LU/LI

____ Dry Cough
____ Cough with sputum
____ Nasal discharge
____ Post-nasal drip
____ Sinus infection / congestion
____ Itchy, red, or painful throat
____ Dry mouth / throat / nose
____ Snoring
____ Grief / Sadness
____ Shortness of breath
____ Allergies / Asthma
____ Low resistance to colds or flu
Sneezing
____ Mild fever comes & goes

SP/ST

____ Heaviness in body
____ Fatigue / Worse after meals
____ Hard to get up in the morning
____ Edema (Swelling)
____ Muscles feel tired often
____ Easily bruising & bleeding
____ Bad breath
____ Decreased / Increased appetite
____ Crave sweets
____ Hypoglycemia
____ Difficulty digesting oily foods
____ Nausea / Vomiting
____ Gas / Belching
____ Hemorrhoids
____ Constipation
____ Diarrhea
____ Abdominal pain
____ Indigestion / heartburn
____ Over-thinking
____ Tendency to gain weight
____ Brain fog

WOMEN ONLY

First day of last period:_____
Number of days bleeding lasts:_____
Number of days for monthly cycle:_____

PMS:

___Cramping ___Clotting ___Fluid retention
___Emotional ___Breast tenderness ___Cravings
___Fatigue ___Bleeding between periods

Women's Health History

___ Endometriosis ___ Pelvic inflammatory disease
___ Uterine fibroids ___Abnormal discharge
___Ovarian cysts ___Infertility
___Hot flashes / sweats

MEN ONLY

___ Impotence
___ Prostate problems
___ Infertility
___ Discharge from penis
___ Testicular pain or lump
___ Premature ejaculation
___ Weak erection
___ Low sex drive
___ Other:

Patient signature:_____Date:_____