Your Health

ACUCARE Total Health

Patient Name ____ **Date** ______________________________________

1. Describe your symptoms: ____

____

When did your symptoms begin: ____

How did your symptoms start: ____

2. How often do you experience your symptoms?

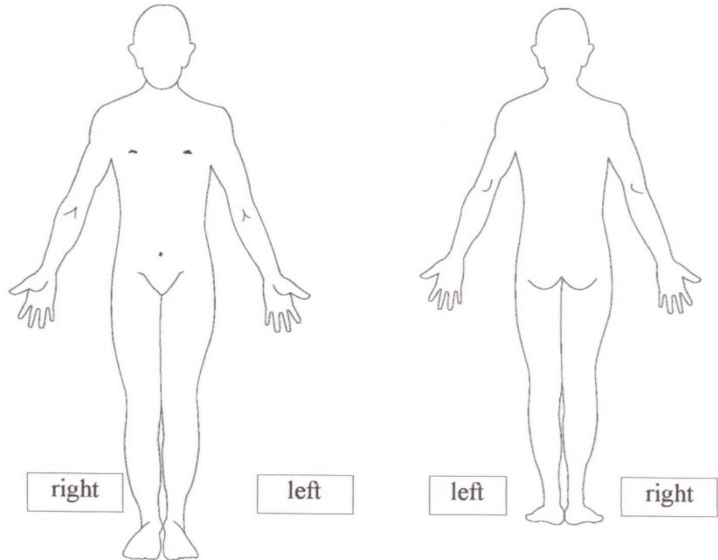
Indicate where you have pain or other symptom.

- o Constantly (76-100% of the day)
- o Frequently (51-75% of the day)
- o Occasionally (26-50% of the day)
- o Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

Please indicate type of pain on the pictures →

- o Sharp (S)
- o Dull ache (D)
- o Numb (N)
- o Shooting (O)
- o Burning (B)
- o Tingling (T)



4. How are your symptoms changing?

- o Getting Better
- o Not Changing
- o Getting Worse

5. During the <u>past 4 weeks</u>:

	None									**Unbearable**	
a. Indicate the average intensity of your symptoms	0	1	2	3	4	5	6	7	8	9	10

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

Not at all   A little bit   Moderately   Quite a bit   Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

All of the time   Most of the time   Some of the time   A little of the time   None of the time

7. In general would you say your overall health right now is…

Excellent   Very Good   Good   Fair   Poor

8. Who have you seen for your symptoms?

No One   Medical Doctor   Other
Other Chiropractor   Physical Therapist

a. What treatment did you receive and when?____

b. What tests have you had for your symptoms and when were they performed?

Xrays date:_______________   CT Scan date:_____________
MRI date: ________________   Other date: ______________

9. Have you had similar symptoms in the past? Yes   No

10. What is your occupation?________________________

Professional/Executive   Laborer   Retired
White Collar/Secretarial   Homemaker   Other
Tradesperson   FT Student

a. If you are not retired, a homemaker or a student, what is your current work status?

Fulltime   Self- employed   Off Work
Part-time   Unemployed   Other

Patient Signature ____ **Date** ________________________________

Your Health History

ACUCARE Total Health

What treatment have you already received for your condition?

( ) Medication ( ) Surger ( ) Physical Therapy ( ) Chiropractic Services ( ) None

Other____

Name and address of other doctor(s) who have treated you for your condition:______________________________

____

Date of last: Physical Exam______________ Spinal Exam__________________ MRI/CT/bone scan______________

Spinal X-ray________________ Blood/Urine test________________

Mark with an X to indicate if you have/had any of the following. Please also mark any that apply to immediate family, and indicate the relationship to you.

( ) AIDS/HIV	( ) Goiter	( ) Pneumonia
( ) Alcoholism	( ) Gonorrhea	( ) Polio
( ) Allergy Shots	( ) Gout	( ) Prostate problems
( ) Anemia	( ) Heart Disease	( ) Prosthesis
( ) Anorexia	( ) Hepatitis	( ) Psychiatric Care
( ) Appendicitis	( ) Hernia	( ) Rheumatoid Arthritis
( ) Arthritis	( ) Herniated Disc	( ) Rheumatic Fever
( ) Asthma	( ) Herpes	( ) Scarlet Fever
( ) Bleeding disorders	( ) High Cholesterol	( ) Stroke
( ) Breast Lump	( ) Kidney Disease	( ) STD
( ) Bronchitis	( ) Liver Disease	( ) Suicide attempts
( ) Bulimia	( ) Measles	( ) Thyroid problem
( ) Cancer	( ) Migraines	( ) Tonsillitis
( ) Cataracts	( ) Miscarriage	( ) Tuberculosis
( ) Chemical dependency	( ) Mononucleosis	( ) Tumors
( ) Chicken Pox	( ) Multiple Sclerosis	( ) Typhoid Fever
( ) Diabetes	( ) Mumps	( ) Ulcers
( ) Emphysema	( ) Osteoporosis	( ) Vaginal Infections
( ) Epilepsy	( ) Pacemaker	( ) Whooping Cough
( ) Fractures	( ) Parkinson	( ) Other:
( ) Glaucoma	( ) Pinched Nerve	

Exercise:	**Work Habits:**	**Other Habits:**	
( ) none	( ) sitting	( ) smoking	Packs/Day__________________________
( ) mild	( ) standing	( ) drinking	Drinks/Week_________________________
( ) moderate	( ) light labor	( ) coffee/caffeine	Cups/Day____________________________
( ) heavy	( ) heavy labor	( ) stress	Reason______________________________

Pregnancy history: # of pregnancies_____ # of live births______

# of miscarriages_____ vaginal/C-section?_________ are you pregnant now?______

If yes, due date?______________

Injuries/Surgeries you have had **Description** **Date**

Falls ____

Head Injuries ____

Broken Bones ____

Dislocations ____

Surgeries ____

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
Please list medications, what they are for, and how long you have been taking them:	________________________	Please list supplements you are currently taking, where you purchased them, and the dose (if known):
1.________________________________	________________________	1.________________________________
2.________________________________	________________________	2.________________________________
3.________________________________	________________________	3.________________________________
4. _______________________________	________________________	4. _______________________________