North Suburban Chiropractic & Acupuncture

Name: ______________________ Date: __________

What is the reason for this visit? ______________________

Date on onset? __________ Have you had this probem in the past? □ Yes □ No

Specify: ______________________

Is this problem: □ Improving □ Consistent □ Getting Worse

What makes it feel better? □ Movement □ Rest □ Heat □ Cold □ Other __________

What makes if feel worse? □ Movement □ Rest □ Heat □ Cold □ Other __________

If there is pain, is it: □ Mild □ Moderate □ Severe □ Sharp □ Dull □ Achy

On a scale of 1 (no pain) to 10 (need hospitalization), what is your pain rate number? __________

Family Medical History

Do you have a family history of any of the following conditions?

□ Cancer □ High Blood Pressure □ Diabetes

□ Allergies □ Depression □ Heart Disease □ Stroke

□ Other:

Medical History

Check the box that pertains

Condition		
Cancer	□ Yes	Date:
Diabetes	□ Yes	Date:
High Blood Pressure	□ Yes	Date:
Hepatitis	□ Yes	Date:
Asthma	□ Yes	Date:
Immune Disorders	□ Yes	Date:

Condition		
Allergies	□ Yes	Date:
Heart Disease	□ Yes	Date:
High Cholesterol	□ Yes	Date:
Thyroid Disorder	□ Yes	Date:
Stroke	□ Yes	Date:
Other	□ Yes	Date:

Digestion

□ Low Appetite □ No Appetite □ Nausea □ Vomiting □ Bloating □ Gas

□ Bad Breath □ Indigestion □ Weight gain □ Weight Loss □ Ulsers □ Heart burn

□ Abdominal pain related to eating: □ Worse before □ Worse after

Do you crave: □ Sweet □ Salty □ Sour □ Spicy food □ Bland

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Name ______________________________

Ear/Eye/Nose/Throat/Mouth				
□ Ringing in the ears:		□ Low pitch	□ High pitch	□ Constant
□ Ear pain	□ Hearing loss	□ Dry eyes	□ Blurred vision	□ Reduced night vision
□ Eye pain	□ Floaters	□ Running nose	□ Sinus congestion	□ Sore throat
□ Nose bleeding	□ Bleeding gums	□ Grinding teeth		

Intestines								
How often to you have a bowel movement:				Per day	______	OR, per week		______
□ Constipation		□ Diarrhea		□ Loose stools		□ Undigested food in stools		
□ Hemorroids		□ Rectal bleeding:		□ Red	□ Brown	□ Black		
Stool is:	□ Hard	□ Dry	□ Pebble-like		□ Urgent	□ Stringy	□ Watery	□ Difficult to pass

Energy		
□ Too much	□ Not enough to get through the day	□ Right amount to complete daily activities
□ Type of daily exercise:		

Sleep			
How many hours a night do you sleep:		______________________	
□ Restful	□ Insomnia:	□ Trouble falling asleep	□ Trouble staying asleep
□ Nightmares	□ Dream disturbed sleep		

Body Temperature					
□ Cold hands	□ Cold feet	□ Feel cold most of the time		□ Chills	□ Hot Flashes
□ Feel hot most of the time		□ Feel hot in:	□ Palms	□ Feet	□ Chest
□ Alternating between hot and cold		□ Fever, temp:	______	□ For how long	______
□ Excess thirst	□ Do you prefer:	□ Cold drinks	□ Hot drinks	□ Room temperature	

Sweating		
□ Night sweats	□ Profuse sweats	□ Sweat easily with little activity
□ Sweaty hands	□ Sweaty feet	

Emotions					
□ Anxiety	□ Easily angered	□ Irritable	□ Nervous	□ Depressed	□ Moody
□ Cry easily	□ Fearful	□ Grieving	□ Joy	□ Worried	□ Manic

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Name ______________________________

Chest/Respiratory

□ Shortness of breath: □ Worse with exertion □ Wheezing □ Chest pain □ Rib pain

□ Dry Cough at: □ Night □ Day □ All the time

□ Productive cough with phlegm: Color: ______________ Consistency: □ Thin □ Thick

□ Chest distention □ Palpitations

Neurological

Headaches: How often? ______________________ Where: ______________________

Known cause? ______________________ □ Vertigo □ Memory loss

□ Dizziness □ Seizures □ Tremors □ Numbness □ Tingling

Where?

Urinary System

□ Frequent urination: □ Day □ Night □ All day □ Difficulty urinating □ Dribbling

□ Urgent □ Incontinence □ Burning urination □ Blood in urine □ Frequent UTI's

Personal Habits

Do you: □ Smoke: How much? ______________

□ Drink alcohol: How much? ______________ □ Drink Coffee: How much? ______________

□ Drink tea: How much? ______________ □ Exercise: How often? ______________

Type of exercise:

Medications/Herbs/Supplements

Please list all, including dose and frequency:

____

____

____

____

____

____

____

____

____

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Name ______________________

Female

Are you pregnant? □ Yes □ No Are you trying to conceive? □ Yes □ No

Date of last period: ____________ Number of days period lasts: ____________

Number of days in cycle: ______ Are your periods regular? □ Yes □ No

Color of mentrual blood: □ Red □ Bright red □ Dark red □ Pale □ Brown □ Watery

Consistency of blood: □ Thin □ Thick □ Watery □ Clotted: □ Small □ Large

Cramps: □ Before period, how many days? ______ □ During, how many days? ______

□ Better with heat □ Better with rest □ Better with movement

□ Breast tenderness □ Mood changes □ Food craving □ Low back pain

□ Spotting between periods □ Hot Flashes □ Vaginal dryness □ Low libido

□ Vaginal discharge: When: ____________ Consistency: ____________ Odor: ______

Male

□ Prostate issues □ Impotence □ Premature ejaculation □ Low libido

Are you and your partner trying to conceive? □ Yes □ No

Any other issues? ______________________

Diet

What do you normally eat? ______________________

How many times a week do you eat in a restaurant? ______ Breakfast ______ Lunch ______ Dinner

What type of restaurants? ______________________

Favorite foods? ____________ Foods you dislike? ____________

Do you crave sweets? □ No □ Yes, When ______________________

Presently, are you on any specific type of diet? ______________________

Do you feel good about your body and your current weight? □ Yes □ No

How does food make you feel: □ Energized □ Sleepy □ Sluggish