

N2Health - Chiropractic & Acupuncture

PATIENT INFORMATION

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email _____

Social Security No. _____ Date of Birth _____ Age _____

Sex: M F Height _____ Weight _____

Marital Status: Married Single Widowed Divorced No. of Children _____

Occupation _____ Employer _____

Employer's Address _____

Spouse's Name _____ Employer _____

Person Responsible for Payment _____

How did you hear about us? _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

ACCIDENT INFORMATION

Is this condition due to an accident? Yes No Date of Injury _____

Type of accident Auto Work Home Other _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How many days per week do you experience this problem? 1-2 3-4 5-6 everyday

What percentage of time do you experience this problem? 25% 50% 75% 100%

Does it interfere with your Work Sleep Daily Routine Recreation

Family members with similar problems: _____

What treatment have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic Acupuncture None
 Other _____

HEALTH HISTORY

Please mark "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|-------------------|--|------------------|--|----------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>Women Only</i> | |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Endometriosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fibrocystic breasts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breast tenderness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fibroids | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Press. | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Cycle | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | | Ovarian Cysts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Pelvic Inflamm. Dis. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>General</i> | | | |
| High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Constipation | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gas / Bloating | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Prostate Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking
- Alcohol
- Coffee/Caffeine
- High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

MEDICATIONS/SUPPLEMENTS	DOSAGE	REASON	HOW LONG?

Injuries/Surgeries _____

Allergies and/or Food Sensitivities _____

Have you received acupuncture before? Yes No Date _____ For _____

Have you received chiropractic before? Yes No Date _____ For _____

WOMEN ONLY

Are you pregnant? Yes No Due Date _____ No. of pregnancies _____

No. of live births _____ No. of abortions _____ No. of miscarriages _____

No. of days between periods less than 26 26-30 more than 30

No. of days of flow _____ Color of flow _____ Clots? Yes No