For Office Use Only

Account Number: _____

Date: _____

Ascension Wellness Center

CHIROPRACTIC & ACUPUNCTURE

Patient Intake Form

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ Phone (Mobile): _____

Date of Birth: ____/____/____ Age: _____ Sex: M/F Marital Status: S M D W

Email Address: _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to Ascension Wellness Center in order of importance below:

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	
c. _____	_____
How does this condition affect you? _____	
d. _____	_____
How does this condition affect you? _____	

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Family History:**

Check those applicable:	Father	Mother	Siblings	Children	Grandparents
Age (if living)	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Asthma/Hay Fever/Hives	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____

9. **Height:** _____ **Weight:** _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles

Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis B

Others: _____

13. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

14. **X-Rays/CAT Scans/MRI's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Anxiety Depression

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids

Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps Breast Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____
2. # of Days of Menses: _____
3. Length of Cycle: _____
4. Birth Control Type: _____
5. # of Pregnancies: _____
6. # of Miscarriages: _____
7. # of Abortions: _____
8. # of Live Births: _____

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Known Issues with Sperm Count/Motility

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Type I or II

Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. How many hours per night do you sleep? _____ Do you wake rested? Y N

d. Level of education completed: High School Bachelors Masters Doctorate Other

e. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

f. Nicotine/Alcohol/Caffeine Use: _____

g. Recreational Drug Use: _____

h. Have you experienced any major traumas? Y N If yes, explain: _____

_____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

How did you hear about Ascension Wellness Center? _____