PRO SPINE & SPORT SOLUTIONS
Relieve pain. Restore function. Return to activity

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This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you

Name_____ Date_____

Home Address_____ City_____

State_____ Zip_____ Home Phone_____ Work_____

Occupation_____ Person Responsible for your account_____

Emergency Contact_____ Phone_____

Who can we thank for referring you?_____

Sex___ M___F Height_____ Weight_____ Birth date_____ Age_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed Number of Children_____

Previous Acupuncture? ☐ yes ☐ no When?_____ With Whom_____

Please indicate any significant illnesses you or a blood relative (grandparent, parent, or sibling) have had

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High blood pressure	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional disorders	☐	☐	_____
Infectious Disease	☐	☐	_____	Tuberculosis	☐	☐	_____

Sexually Transmitted disease: ☐ gonorrhea ☐ syphilis ☐ HIV ☐ HPV ☐ chlamydia ☐ herpes Date: _____

Please indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount		Yes	No	Amount
Coffe/black tea	☐	☐	_____	Tobacco	☐	☐	_____	Water intake	☐	☐	_____
Recreational drugs	☐	☐	_____	Alcohol	☐	☐	_____	Soda Pop	☐	☐	_____

Please check the box if any of the following statements are true:

I have known allergies ☐ I am taking Coumadin / Warfarin ☐

I have a pacemaker ☐ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs) ☐

List any medications and supplements you are currently taking: (continue on the back if needed)

Medicine	Dosage	Reason	How Long	Prescribed by	Date last checkup

For Women

Age of 1st period (menarche)_____ Are you pregnant? □Yes □ No # of pregnancies_____
Age of last period (menopause)_____ # of live births_____ # of abortions_____ # of miscarriages_____
Number of days between periods_____ Date of last gynecological exam_____ Pap smear_____
Number of days of flow_____ Mammogram_____ Bone density scan_____
Color of flow_____ Results_____
Clots? □ Yes □ No Color_____ _____
Average number of pads you use per day: 1st day_____ 2nd day_____ 3rd day_____ 4th day_____ +days_____
Have you been diagnosed with: □ Fibroids □ Fibrocystic Breasts □ Endometriosis □ Ovarian Cysts □ PID Other_____
Location of Pain: □ Lower abdomen □ Lower back □ Thighs □ Other_____
Nature of pain: (please indicate before, during or after menses) Other symptoms related to menses

Cramping_____	Stabbing_____	□ Discharge	□ Vaginal dryness	□ Headache
Burning_____	Aching_____	□ Nausea	□ Constipation	□ Diarrhea
Dull_____	Bloating_____	□ Swollen breasts	□ Mood swings	□ Ravenous appetite
Consistent_____	Intermittent_____	□ Poor Appetite	□ Hot flashes	□ Night sweats
Bearing down sensation_____		□ Increased libido	□ Decreased libido	□ Insomnia

For Men

Date of last prostate check up_____ PSA results_____ Manual prostate exam results_____
Lab results_____
Frequency of urination: daytime_____ night time_____ Color of urine: □ clear □ murky odor:_____
Symptoms related to prostate

□ Prostate problems	□ Delayed stream	□ Dribbling	□ Incontinence	□ Retention of urine
□ Rectal dysfunction	□ Increased libido	□ Decreased libido	□ Premature ejaculation	□ Impotence
□ Back pain	□ Groin pain	□ Testicular pain	Other_____	

Symptom Survey (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
no mark ( ) = never experience **check mark** (√) = sometimes experience **Plus sign** (+) = frequently experience

___ lack of appetite
___ excessive appetite
___ loose stool or diarrhea
___ digestive problems, indigestion
___ vomiting
___ belching, burping
___ heartburn/ reflux
___ feeling the retention of food in the stomach
___ tendency to become obsessive in work relationships

___ insomnia, difficulty sleeping
___ heart palpitations
___ cold hands and feet
___ nightmares
___ mentally restless
___ laughing for no apparent reason
___ angina pains
___ abdominal pain
___ chest pain
___ sciatic pain
___ headaches
___ pain pr coldness in the genital area

___ cough
___ shortness of breath
___ decreased sense of smell
___ nasal problems
___ skin problems
___ feeling of claustrophobia
___ bronchitis
___ colitis or diverticultis
___ constipation
___ hemorrhoids
___ recent use of antibiotics
___ eye problems
___ jaundice (yellowish eyes or skin)
___ difficulty digesting oily foods
___ gall stones
___ light colored stool
___ soft or brittle nails
___ easily angered or agitated
___ difficulty in making plans or decisions
___ spasms or twitching of muscles

___ low back pain
___ knee problems
___ hearing impairment
___ ear ringing
___ kidney stones
___ decreased sex drive
___ hair loss
___ urinary problems
___ fatigue
___ edema
___ blood in stool
___ black tarry stool
___ easily bruised
___ difficult stop bleeding
___ asthma
___ tendency to catch colds easily
___ intolerance to weather changes
___ allergies
___ hay fever
___ dizziness
___ tendency faint easily
___ high cholesterol levels
___ sudden weight loss

What are the main health problems for which you are seeking treatment?

_____

_____

Which other forms of treatment have you sought? _____

_____

_____

List any other health problems you now have

_____

_____

_____

_____

List any allergies, food sensitivities or food craving that you have. _____

_____

_____

_____

List any accidents, surgeries, or hospitalizations (include date). _____

_____

_____

_____

_____

Lab Results: (please include copies)_____

_____

_____

Clinical Notes

How do you FEEL about the following areas of your life? Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	**Good**	**Fair**	**Poor**	**Bad**	**Your Comments**
Significant Other	□	□	□	□	□	_____
Family	□	□	□	□	□	_____
Diet	□	□	□	□	□	_____
Sex	□	□	□	□	□	_____
Self	□	□	□	□	□	_____
Work	□	□	□	□	□	_____
Exercise	□	□	□	□	□	_____
Spirituality	□	□	□	□	□	_____

Patient Pain Drawing

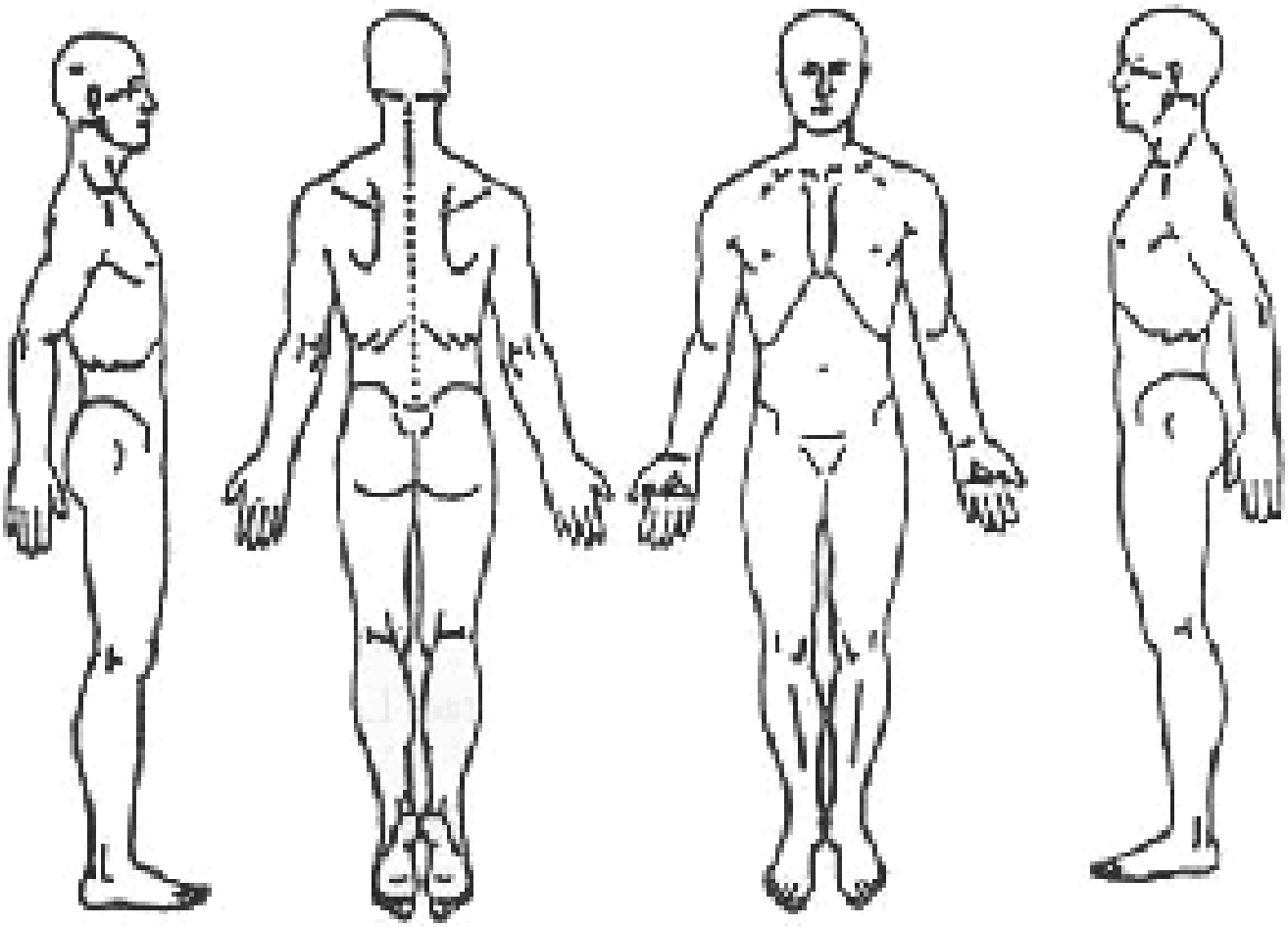
Patient Name_____ **Date:**_____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Ache	Numbness	Pins & needles	Burning	Stabbing
ΔΔΔΔΔ	======	OOOOOO	XXXXXX	///////

Back **Front**

Pain in arms compared to neck
□ worse than
□ same as
□ less than



Pain in leg(s) compared to neck
□ worse than
□ same as
□ less than