Infinity Chiropractic & Wellness Center

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be held absolutely confidential.* If you have any questions, please feel free to ask.

Date: _____ email:_____

Cell Phone: _____

Name: _____ Home Phone: _____

Address: _____ City: _____ State/Zip: _____

Date of Birth: _____Age: _____ Marital Status:_____SS #_____

Occupation: _____ Family Physician/phone: _____

Emergency Contact/ Phone: _____ Relation: _____

Have you been treated by acupuncture or Oriental Medicine Before? ○Yes ○No

Main problems to be addressed:

_____

How long ago did this problem begin?

_____

Affected daily activities (work, sleep, sex, etc.):

_____

Have you been given a Diagnosis for this problem? Please explain:

_____

What other kinds of treatment have you tried?

_____

Past Medical History (please include date)
Significant Illnesses (please circle all applicable)

Cancer Diabetes Depression High Blood Pressure Heart Disease Seizures

Rheumatic Fever Thyroid Disease Venereal Disease Other: _____

Surgeries:

_____

Significant Trauma:

_____

Allergies (drugs, chemicals, foods)

_____

Family Medical History (please circle all applicable)

Asthma Allergies Diabetes Cancer Heart Disease High Blood Pressure

Stroke Seizures Thyroid Disease Other: _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.)

_____

Occupational Stress (chemical, physical, psychological, etc.)

_____

Do you have a regular exercise program? Please explain.

_____

Have you ever been on a restricted Diet? If yes, what kind?

_____

Please describe your average daily Diet:

Morning: Afternoon: Evening:

Do you smoke? If so, how much?

_____

How much caffeinated coffee, tea, or cola do you drink per week?

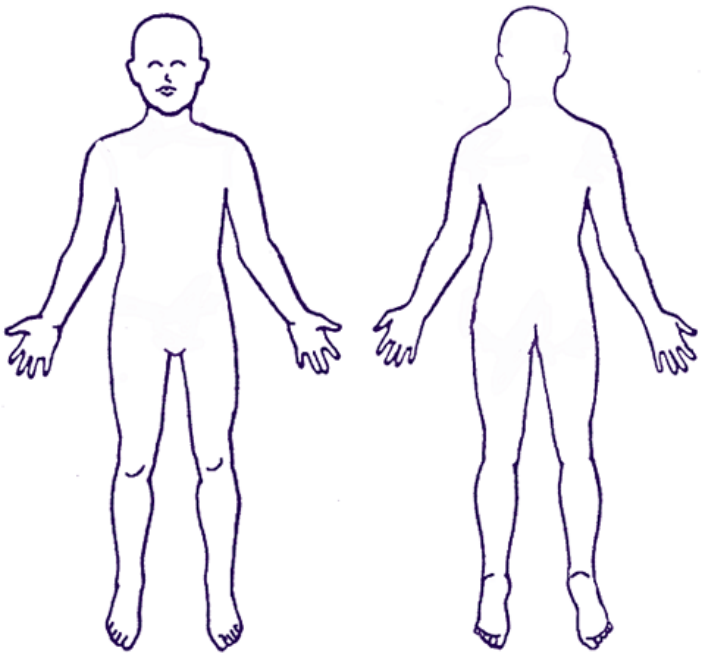
_____

How much water do you drink per day? How much alcohol do you drink?

_____

Please describe any use of drugs for non-medical purposes.

Please circle areas of pain, distress or discomfort:



Name: _____ Date: _____

Please check if you have had (in the last three months):

General

- ○ Fevers
- ○ Sweat easily
- ○ Night Sweats
- ○ Chills
- ○ Bleed or Bruise easily
- ○ Peculiar tastes or smells
- ○ Cravings
- ○ Change in appetite
- ○ Weight loss
- ○ Weight gain
- ○ Strong thirst (hot or cold)
- ○ Poor Sleep
- ○ Fatigue
- ○ Sudden energy drop (time of day)

Skin and Hair

- ○ Rashes
- ○ Itching
- ○ Dandruff
- ○ Change in hair or skin texture
- ○ Any other hair or skin problems?
- ○ Ulcerations
- ○ Eczema
- ○ Loss of Hair
- ○ Hives
- ○ Pimples
- ○ Recent moles

Head, eyes, ears, nose, and throat

- ○ Dizziness
- ○ Glasses
- ○ Poor Vision
- ○ Cataracts
- ○ Ringing in the ears
- ○ Sinus problems
- ○ Grinding teeth
- ○ Teeth problems
- ○ Any other head or neck problems?
- ○ Concussions
- ○ Eye Strain
- ○ Night Blindness
- ○ Blurry Vision
- ○ Poor Hearing
- ○ Nose Bleeds
- ○ Facial pain
- ○ Jaw Clicks
- ○ Migraines
- ○ Eye pain
- ○ Color Blindness
- ○ Earaches
- ○ Spots in front of eyes
- ○ Recurrent sore throats
- ○ Sores on lips or tongue
- ○ Headaches (where, when?)

Cardiovascular

- ○ Chest pain
- ○ Irregular heartbeat
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Any other heart or blood vessel problems?
- ○ Fainting
- ○ Cold hands or feet
- ○ Swelling feet
- ○ Swelling hands
- ○ Blood Clots
- ○ Phlebitis
- ○ Peripheral Arterial Sclerosis
- ○ Varicose veins

Respiratory

- ○ Cough
- ○ Coughing blood
- ○ Bronchitis
- ○ Pneumonia
- ○ Production of phlegm. What color?
- ○ Any other lung/breathing problems?
- ○ Asthma
- ○ Difficulty Breathing
- ○ Wheezing while breathing
- ○ Difficulty in breathing when lying down
- ○ Shortness of breath
- ○ Pain with a deep breath

Gastrointestinal

- ○ Nausea
- ○ Constipation
- ○ Blood in stools
- ○ Black stools
- ○ Any other problems with your stomach or intestines?
- ○ Diarrhea
- ○ Rectal Pain
- ○ Hemorrhoids
- ○ Bleeding gums
- ○ Vomiting
- ○ Gas
- ○ Bad Breath
- ○ Chronic laxative use
- ○ Abdominal pain or cramps
- ○ Indigestion
- ○ Belching

Urinary

- ○ Frequent urination
- ○ Urgency to urinate
- ○ Unable to hold urine
- ○ Pain upon urination
- ○ Blood in urine
- ○ Decrease in flow
- ○ Kidney stones
- ○ peculiar color of urine
- ○ Wake to urinate? How often?
- ○ Any other problems with your urinary system?

Male Reproductive System

- ○ Impotence
- ○ Prostatitis
- ○ Prostate Cancer
- ○ Benign Prostatic Hypertrophy
- ○ Premature Ejaculation
- ○ Spermatorrhea
- ○ Low Sperm count
- ○ Low motility
- ○ Testicular pain/injury
- ○ Testicular Cancer
- ○ Sores on genitals
- ○ STDs
- ○ Any other reproductive problems?

Female Reproductive System

Are you pregnant? ○ Yes ○ No

Is it possible that you are pregnant? ○ Yes ○ No

- ○ Age of first menses: _____
- ○ Duration of menses: _____
- ○ Time between menses: _____
- ○ Irregular periods
- ○ Painful periods
- ○ Unusual character (heavy/light)
- ○ Clots
- ○ Pregnancies #: _____
- ○ Live births #: _____
- ○ Premature births #: _____
- ○ Miscarriages #: _____
- ○ Abortions #: _____
- ○ Infertility
- ○ Western Fertility Treatments
- ○ Menopause Age: _____
- ○ Last PAP: _____
- ○ Vaginal discharge
- ○ Breast lumps
- ○ Sores on genitals
- ○ STDs
- ○ Changes in body/psyche prior to menstruation
- ○ Do you practice birth control? What type and for how long? _____
- ○ Any other reproductive problems?

Musculoskeletal

- ○ Neck pain
- ○ Shoulder pain
- ○ Back pain
- ○ Hand/wrist pain
- ○ Hip pain
- ○ Knee pain
- ○ Foot/ankle pain
- ○ Muscle pain
- ○ Muscle weakness
- ○ Any other muscle, joint or bone problems

Neurological

- ○ Seizures
- ○ Stroke
- ○ Concussion
- ○ Dizziness
- ○ Loss of Balance
- ○ Lack of Coordination
- ○ Areas of numbness
- ○ Poor memory
- ○ Tremors (where?)
- ○ Any other neurological problems?

Psychological

- ○ Depression
- ○ Anxiety
- ○ Fearful
- ○ Easily angered
- ○ Easily susceptible to stress
- ○ Easily over worried
- ○ Sadness
- ○ Overly joyful

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

○ Any other psychological problems?