



ACUPUNCTURE HORIZONS

855 Davis Blvd. Suite 300

Southlake TX 76092

Clinic: 817 291-0371

Name: _____ Date: _____

DOB: ___/___/___ Age: ___ M F Social Security # (last four digits) _____

Address: _____

City _____ State _____ Zip code _____

Phone number: Please circle the best way to contact you

Home: _____ Cell phone: _____ Work: _____

E-mail: _____

May we leave a voice mail with information concerning your appointments? Yes No

Please check preferred notification: Home phone Cell phone Work phone E-mail

Occupation: _____ Full Time Part Time Night shift Day Shift

Marital status: Single Married Life Partner Divorced Widowed

Primary Care Physician and phone # _____

In case of an emergency contact: _____

Phone: _____ Relationship to you _____

How did you find out about us?

Newspaper Telephone directory Web Site Other

Who may we thank for this referral?

Friend _____ Doctor _____

Chiropractor _____ Other _____

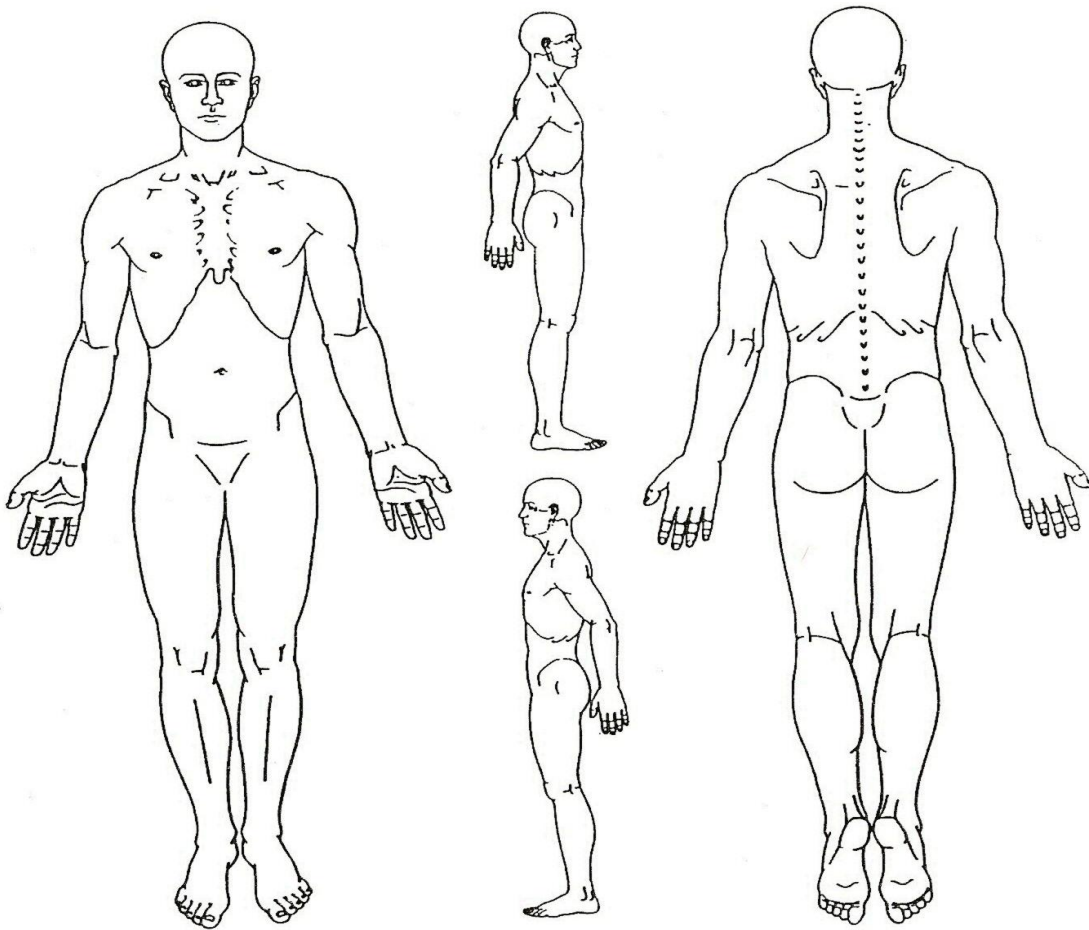
I have completed the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with current State and Federal laws, for the management of my healthcare.

Patient signature: _____

Parent's signature of minor patient; _____

Relationship to the patient: _____

May we call you for follow up after treatment? Yes No



Please mark the area of pain and indicate the type and severity of pain.

Pain scale 1 to 10, very mild=1, moderate= 5, excruciating=10.

A: aching B: burning N: numbness P: pins and needles S: stabbing

O: other

How long have you had this pain? _____

How did this happen? _____

What makes it better? _____

What makes it worse? _____

How does this affect you emotionally? _____

How does this effect your daily activities?

What other treatments have you had for this condition?

Please mark any of the conditions that you have had:

Past Medical History:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Birth Trauma (yours) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Measles | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke | |

List Medications you are presently taking.

<u>Medication</u>	<u>Strength</u>	<u>Dosage</u>	For how long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Allergies (medications or substances)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any Surgeries you have had

<u>Date</u>	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Problem

List any significant trauma

Date

Problem

_____	_____
_____	_____
_____	_____
_____	_____

Significant Family History

	Ages	Deceased? Y/N	Significant Medical problems
Mother			
Father			
Sisters			
Brothers			
Your birth order in the family, age of parents at conception			

Your Diet

- | | | | |
|---|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Appetite high | <input type="checkbox"/> Coffee | <input type="checkbox"/> Thirsty | <input type="checkbox"/> Fast food |
| <input type="checkbox"/> Appetite Low | <input type="checkbox"/> Crave sweet | <input type="checkbox"/> No thirst | <input type="checkbox"/> Fresh fruit |
| <input type="checkbox"/> Sugar | <input type="checkbox"/> Crave salty | <input type="checkbox"/> Thirst for hot | <input type="checkbox"/> Vegetables |
| <input type="checkbox"/> Artificial sweetener | <input type="checkbox"/> Crave sour | <input type="checkbox"/> Thirst for cold | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Soft Drinks | <input type="checkbox"/> Crave spicy | <input type="checkbox"/> Vitamins daily | |

How much water do you drink per day? _____ 8oz glasses.

Your Lifestyle

- | | | |
|--|---|----------------------------------|
| <input type="checkbox"/> Alcohol use | Type_____ | # of drinks _____ |
| <input type="checkbox"/> Tobacco | Cigarettes per day _____ | Other pipe/ cigar etc _____ |
| <input type="checkbox"/> Recreational drug use | <input type="checkbox"/> Marijuana | Pharmaceutical addiction _____ |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Home <input type="checkbox"/> Work | |
| <input type="checkbox"/> Occupational hazards | Type_____ | Regular Exercise _____x per week |

General Symptoms

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Recent Weight loss | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Recent Weight Gain | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Vertigo or dizziness | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Dream disturbed sleep | <input type="checkbox"/> Cold hand and feet | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Fever/chills |

Head, Eye, Ears, Nose and Throat

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Lumps in throat |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Grind teeth | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Ringing of the ears |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> TMJ pain | <input type="checkbox"/> Excessive phlegm | Poor hearing |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Facial pain / numbness | Color of _____ | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Sores on lips or tongue | | <input type="checkbox"/> Concussions |

Respiratory

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma / wheezing | Color of phlegm _____ |
| <input type="checkbox"/> Difficulty breathing lying down | <input type="checkbox"/> Cough <input type="checkbox"/> Wet <input type="checkbox"/> dry | _____ |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Phlegm <input type="checkbox"/> thick <input type="checkbox"/> thin | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Tightness of chest | | |

Cardiovascular

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart valve problems | <input type="checkbox"/> Irregular heart rhythm | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Stents in heart | <input type="checkbox"/> Slow heart rate | <input type="checkbox"/> Fainting | |
| <input type="checkbox"/> Open heart surgery | <input type="checkbox"/> Fast heart rate | <input type="checkbox"/> Pacemaker | |

Gastrointestinal

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Itchy anus |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bloating | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Burning anus |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Anal fissures |
| <input type="checkbox"/> Antacid use | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Constipation | <input type="checkbox"/> Intestinal pain or cramping | |

Bowel movements; Frequency _____, color _____
Odor _____ texture, form _____

Musculoskeletal

- | | | | |
|---|--|-------------------------------------|--|
| <input type="checkbox"/> Neck / shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Limited use |

Other describe: _____

Skin and Hair

- | | | | |
|--------------------------------------|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Fungal infection |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Ridges in nails |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Splitting nails |

Other hair or skin problems, describe: _____

Neuropsychological

- | | | | |
|-----------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered / attempted |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> suicide |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Seeing a therapist |

Other problems describe: _____

Genitourinary

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Incontinent | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Low libido |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Excessive libido |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Impotence | |

Gynecological

Age menses began: _____, length of monthly cycle _____ days, and length of menstrual flow _____ days

Date last period started _____, Date of last PAP test _____

of pregnancies _____ # of live births _____ # of miscarriages _____ # of premature births _____

Age of menopause _____ are you taking HRT Y or N, type _____

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Irregular period | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> PMS | <input type="checkbox"/> HX of ovarian cancer |
| <input type="checkbox"/> Painful period | <input type="checkbox"/> Color _____ | <input type="checkbox"/> Breast lumps | |
| <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> Clots Y N | <input type="checkbox"/> HX of breast cancer | |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Color _____ | <input type="checkbox"/> HX of uterine cancer | |

Other describe: _____