INITIAL INTAKE FORM

Name ______________________________ Today's Date ______________________________

Address ______________________________ Birthdate ______________________________

______________________________ Occupation ______________________________

Phone: Home ______________________ Work ______________________ Cell ____________________

Email address ______________________________ Referred by ______________________________

Physician ______________________________ Physician's Phone ______________________________

Chiropractor ______________________________ Other healthcare givers ______________________________

Reason for visit today ____

Current medications, herbs, supplements ____

____

____

Your Past Medical History

Check any of the following you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

☐ AIDS/HIV
☐ Alcoholism
☐ Allergies
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Birth Trauma (your own birth)
☐ Cancer
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Measles
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Stroke
☐ Surgery (list)
____
____
____
☐ Thyroid Disorders
☐ Major Trauma (car, fall, etc., list)
____
____
____
☐ Tuberculosis
☐ Typhoid Fever
☐ Ulcers
☐ Venereal Disease
☐ Whooping Cough
☐ Other (Specify)
____
____
____
____

Auto Accident Clients Only:

Insurance Co. ________________________ Address & Phone ________________________

Policy No. ________________________ ________________________

Claim No. ________________________ Contact Person ________________________

Date of Accident ________________________

PATIENT SYMPTON SURVEY

Patient Name ____ Date ___________

Please check your past and present symptoms so we can better evaluate your condition.

GENERAL
Past Now
☐ ☐ Fatigue
☐ ☐ Sleep problems
☐ ☐ Swollen glands
☐ ☐ Hot or cold intolerance
☐ ☐ Frequent headaches
☐ ☐ Weight loss
☐ ☐ Weight gain
☐ ☐ Fever or chills
☐ ☐ Allergies

NERVOUS SYSTEM
Past Now
☐ ☐ Dizziness
☐ ☐ Blurred vision
☐ ☐ Fainting
☐ ☐ Paralysis
☐ ☐ Tremors
☐ ☐ Numbness/tingling
☐ ☐ Convulsions
☐ ☐ Imbalance
☐ ☐ Memory loss
☐ ☐ Muscle weakness

URINARY
Past Now
☐ ☐ Painful urination
☐ ☐ Frequent urination
☐ ☐ Hard to urinate
☐ ☐ Incontinence
☐ ☐ Bed wetting
☐ ☐ Discolored urine
☐ ☐ Frequent infections
☐ ☐ Prostate problems
☐ ☐ Unusual discharge

HEAD
Past Now
☐ ☐ Headache
☐ Entire head
☐ Back of head
☐ Forehead
☐ Temples
☐ Migraine
☐ ☐ Head feels heavy
☐ ☐ Loss of memory
☐ ☐ Lightheadedness
☐ ☐ Light bothers eyes
☐ ☐ Loss of smell
☐ ☐ Loss of taste
☐ ☐ Loss of balance
☐ ☐ Dizziness
☐ ☐ Loss of hearing
☐ ☐ Pain in ears
☐ ☐ Ringing in ears
☐ ☐ Buzzing in ears

NECK
Past Now
☐ ☐ Pain in neck
☐ ☐ Neck pain w/ movement
☐ ☐ Pinched nerve in neck
☐ ☐ Neck feels out of place
☐ ☐ Stiff neck
☐ ☐ Muscle spasms in neck
☐ ☐ Grinding sounds in neck
☐ ☐ Grating sounds in neck
☐ ☐ Popping sounds in neck
☐ ☐ Arthritis in neck

EMOTIONAL
Past Now
☐ ☐ Anxiety or worry
☐ ☐ Frequent crying
☐ ☐ Anger
☐ ☐ Tension
☐ ☐ Mood swings
☐ ☐ Fear
☐ ☐ Restlessness
☐ ☐ Confusion
☐ ☐ Depression
☐ ☐ Suicidal

REPRODUCTIVE SYSTEM
Past Now
☐ ☐ Painful intercourse
☐ ☐ Prostate problems
☐ ☐ Sexual problems
☐ ☐ Loss of sex drive
☐ ☐ Genital infections
Birth control method:
____

Women only
Past Now
☐ ☐ Cramps
☐ ☐ PMS
☐ ☐ Irregular periods
Are you pregnant?
☐ Yes ☐ No
Date last period __________
# of pregnancies _________
# of miscarriages _________
# of abortions ____________
Date of last PAP __________
☐ ☐ Difficult labor
☐ ☐ Breast problems

LOW BACK
Past Now
☐ ☐ Low back pain
Low back pain is worse when:
☐ Working
☐ Lifting
☐ Stooping
☐ Standing
☐ Sitting
☐ Bending
☐ Coughing
☐ ☐ Pinched nerve in low back
☐ ☐ Slipped disk
☐ ☐ Feels out of place
☐ ☐ Muscle spasms
☐ ☐ Arthritis

MID BACK
Past Now
☐ ☐ Mid back pain
☐ ☐ Pain between shoulder blades
☐ ☐ Sharp stabbing pain in mid back
☐ ☐ Muscle spasms

CHEST
Past Now
☐ ☐ Chest pain
☐ ☐ Shortness of breath
☐ ☐ Breath pain around ribs

EENT
Past Now
☐ ☐ Earache
☐ ☐ Ear discharge
☐ ☐ Ringing in ears
☐ ☐ Hearing loss
☐ ☐ Nose bleeds
☐ ☐ Hoarseness
☐ ☐ Problems swallowing
☐ ☐ Sore throat
☐ ☐ Jaw tight or sore
☐ ☐ Dental problems
☐ ☐ Glasses/contacts

MUSCULOSKELETAL

Past Now

- ☐ ☐ Joint swelling
- ☐ ☐ Muscle cramps
- ☐ ☐ Neck pain
- ☐ ☐ Shoulder pain
- ☐ ☐ Tennis elbow
- ☐ ☐ Arm pain
- ☐ ☐ Hand sensations
- ☐ ☐ Loss of grip
- ☐ ☐ Mid back pain
- ☐ ☐ Rib pain
- ☐ ☐ Low back problems
- ☐ ☐ Hip pain
- ☐ ☐ Foot problems
- ☐ ☐ Leg cramps
- ☐ ☐ Knee pain
- ☐ ☐ Ankle weakness
- ☐ ☐ Tingling foot

SHOULDERS

Past Now

- ☐ ☐ Pain in shoulder joint
- ☐ ☐ Pain across shoulders
- ☐ ☐ Bursitis (R-L)
- ☐ ☐ Arthritis (R-L)
- ☐ ☐ Can't raise arm
  - ☐ Above shoulder level
  - ☐ Over head
- ☐ ☐ Tension in shoulders
- ☐ ☐ Pinched nerve in shoulder
- ☐ ☐ Muscle spasms in shoulder

ARMS & HANDS

Past Now

- ☐ ☐ Pain in upper arm
- ☐ ☐ Pain in forearm
- ☐ ☐ Pain in hands
- ☐ ☐ Pain in fingers
- ☐ ☐ Pinched nerve in arm
- ☐ ☐ Pinched nerve in fingers
- ☐ ☐ Pins & needles in arms
- ☐ ☐ Pins & needles in fingers
- ☐ ☐ Fingers go to sleep
- ☐ ☐ Hands cold
- ☐ ☐ Swollen joints in fingers
- ☐ ☐ Arthritis in fingers
- ☐ ☐ Loss of grip strength

HEART/LUNG

Past Now

- ☐ ☐ Chest pain
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Persistent cough
- ☐ ☐ Hard to breathe
- ☐ ☐ Coughing blood
- ☐ ☐ Coughing phlegm
- ☐ ☐ Irregular heartbeat
- ☐ ☐ Varicose veins
- ☐ ☐ Ankle swelling

GASTROINTESTINAL

Past Now

- ☐ ☐ Change in appetite
- ☐ ☐ Thirst
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Gas
- ☐ ☐ Hemorrhoids
- ☐ ☐ Gall bladder
- ☐ ☐ Belching
- ☐ ☐ Heartburn
- ☐ ☐ Abdominal pain
- ☐ ☐ Bloody/black stools
- ☐ ☐ Indigestion
- ☐ ☐ Liver trouble

SKIN

Past Now

- ☐ ☐ Easy bruising
- ☐ ☐ Dry skin
- ☐ ☐ Itching
- ☐ ☐ Boils
- ☐ ☐ Rashes
- ☐ ☐ Excessive sweat
- ☐ ☐ Hair changes

HIPS, LEGS & FEET

Past Now

- ☐ ☐ Pain in buttocks (R-L)
- ☐ ☐ Pain in hip joint (R-L)
- ☐ ☐ Pain down leg (R-L)
- ☐ ☐ Pain down both legs
- ☐ ☐ Leg cramps
- ☐ ☐ Pins & needles in legs
- ☐ ☐ Numbness of leg (R-L)
- ☐ ☐ Numbness of feet (R-L)
- ☐ ☐ Numbness of toes
- ☐ ☐ Feet feel cold
- ☐ ☐ Cramps in feet (R-L)
- ☐ ☐ Swollen ankles (R-L)
- ☐ ☐ Swollen feet (R-L)
- ☐ ☐ Painful joints in toes
- ☐ ☐ Pain in foot (R-L)
- ☐ ☐ Pain in knee (R-L)

GENERAL

Past Now

- ☐ ☐ Nervousness
- ☐ ☐ Irritable
- ☐ ☐ Depressed
- ☐ ☐ Fatigue
- ☐ ☐ Generally feel run down
- ☐ ☐ Loss of sleep
- ☐ ☐ Loss of weight

CANCELLATION POLICY

Effective immediately, there is a 24 hour cancellation policy in effect. Please call the office at 412 363 0886 (no text or email!) at least 24 hours ahead of your scheduled appointment if you need to cancel. Failure to do so will result in you being charged a $75 fee.

For my part, if I should ever forget or miss your scheduled appointment time, I will give you a treatment free of charge. Thank you in advance for your cooperation.

David Mortell, R.Ac.
www.pittsburghacupuncturecenter.com