

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.

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

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 \$65 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