3804 1st Ave NE, Cedar Rapids Iowa 52402 319-362-8800

CONFIDENTIAL ACUPUNCTURE HEALTH HISTORY QUESTIONNAIRE

Please take the time to fill out this questionnaire to the best of your ability.

NAME:_____DATE:_____
DOB:_____

ADDRESS (include street, apt. #, city, state, zip):

_____

EMAIL:_____ CELL:_____

CELL CARRIER:_____ (For reminder Texts) Is it ok to leave a text message, appointment reminder, or voicemail to the above numbers? (Y / N) Would you like to join our emailing list? (Y / N)

AGE:_____ HEIGHT:_____ WEIGHT_____ OCCUPATION:_____

EMERGENCY CONTACT:

Name:_____Phone:_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

HAVE YOU EVER RECEIVED ACUPUNCTURE BEFORE? (Y / N)

MAIN PROBLEM: What has brought you to Mind, Body & Spirit Chiropractic?

_____
_____
_____

MAJOR ILLNESSES:

_____
_____

RECENT TESTS : Xrays, MRI, CT, Ultrasound, Blood Tests or Special Tests (in the last year):_____

PAST AND PRESENT MEDICAL HISTORY: (please check all applicable) □ HIV □ Hepatitis □ Cancer □ Bleeding Tendency □ Anemia □ Blood disorders □ Heart disease □ High Blood Pressure □ High Cholesterol □ Diabetes □ Low blood sugar/hypoglycemic □ Glaucoma □ Thyroid disease □ Kidney stones □ Multiple Sclerosis □ Mononucleosis □ Epilepsy □ Seizures □ Gout □ Gallbladder stones □ Jaundice □ Fatty liver/Liver disease □ Fatigue □ Auto-Immune _____

FAMILY MEDICAL HISTORY: □ High Blood Pressure □ Heart Disease □ High Cholesterol □ Stroke □ Cancer □ Diabetes □ Seizures □ Mental illness □ Allergies □ Other:_____

Current Medications Herbs/Vitamins/Supplements and reason for taking:

_____

_____

Allergies (drugs, chemicals, foods, seasonal, etc)

_____

Please list any Hospitalizations/Surgeries/Significant Trauma

_____

_____

Any implants, devices, or prosthetics (metal or plastic)? _____

LIFESTYLE: Caffeine (intake per day):_____Water (intake per day):_____ Smoking/ Chew (# of packs/day):_____ Alcohol (# of drinks daily):_____ Recreational Drugs: (Y / N)

DIET: □ Strong thirst □ No thirst □ Water retention □ Particular tastes/smells □ Weight gain □ Weight loss □ Increase/decrease in appetite □ Cravings:_____

Do you follow a prescribed diet or have food restrictions/sensitivities?

_____

Eat Whole Foods? _____ Eat Processed Foods?_____ Eat Combination of Whole Foods / Processed Foods?_____

How many hours per week do you work?_____

Do you have a regular exercise program? (type of exercise and times per week)_____

	Lowest									Highest
Stress Level:	1	2	3	4	5	6	7	8	9	10
Energy Level:	1	2	3	4	5	6	7	8	9	10

OVERALL TEMPERATURE: □ Cold hands/feet □ Raynaud's disease □ Cold abdomen □ Cold body temp. (sensation) □ Hot body temp. (sensation) □ Night sweats □ Sweaty hands/feet □ Heat in hands, feet, chest □ Hot flashes (any time of day) □ Spontaneous sweating □ Lack of perspiration □ Chills

SKIN & HAIR: □ Dry □ Oily □ Acne □ Dandruff □ Loss of hair □ Eczema/Psoriasis □ Itching □ Rashes □ Hives □ Ulcerations □ Lumps/cysts □ Warts □ Recent moles □ Change in hair or skin texture? □ Any other hair or skin problems:_____

HEAD, EYES, EARS, NOSE, MOUTH and THROAT: □ Glasses/Contacts □ Night blindness □ Dizziness/Vertigo □ Facial pain □ Blurry vision/Eye strain □ Sinus problems □ Nose bleeds □ Tearing/ Dryness □ Hearing loss □ TMJ/Jaw problems □ Recurrent sore throats □ Floaters/spots □ Ear ringing/ Tinnitus □ Teeth grinding/clenching □ Sores on lips/tongue □ Cataracts □ Earaches/infections □ Teeth problems □ Bleeding gums □ Concussions □ Headaches/Migraines (location on head/ frequency):_____ □ Any other face or head problems: _____

CARDIOVASCULAR: □ Irregular heart beat □ Chest pain/tightness □ Palpitations □ High blood pressure □ Low blood pressure □ Varicose veins □ Swelling of the hands/feet □ Blood clots □ Murmur □ Phlebitis □ Fainting □ Pacemaker □ Any other heart or blood vessel prob-
lems:_____

RESPIRATORY: □ COPD □ Persistent cough □ Difficulty breathing/Shortness of breath □ Emphysema □ Asthma □ Frequent colds □ Bronchitis □ Coughing blood □ Pain with a deep breath □ Pneumonia □ Post nasal drip □ Allergies □ History of smoking: ____When did you quit?)_____ Any other lung/breathing problems:_____

GASTROINTESTINAL: □ Passing gas □ Belching □ Heartburn/Acid reflux/GERD □ Ulcers □ Abdominal bloating □ Abdominal/Epigastric Pain □ Nausea □ Vomiting □ IBS □ Crohn's disease □ Polyps □ Diverticulitis □ Colitis □ Any other problems with your stomach or intes-
tines:_____

ELIMINATION/BOWELS: □ Constipation □ Diarrhea □ Loose stools □ Black stools/blood in stool □ Hemorrhoids □ Rectal pain □ Undigested food in stools □ Chronic laxative use □ How often do you have a bowel movement per week?_____

URINARY: □ Pain upon urination □ Frequent urination □ Blood in urine □ Urgency to urinate □ Unable to hold urine □ Incontinence □ Decrease in flow □ Frequent UTI or bladder infections □ Cloudy urine □ Scanty urination □ Profuse urination □ Strong odor □ Do you wake to urinate? How often? _____ Color of urine:_____ □ Any other problems with your urinary system:_____

MALE REPRODUCTIVE: □ Erectile Dysfunction □ Prostate problems □ Testicular pain/swelling □ Impotence □ Premature ejaculation □ Cold/numbness in external genitals □ Any other problems with your reproductive system:_____

FEMALE REPRODUCTIVE: □ Are you pregnant?_____ □ Is it possible you are pregnant? _____ □ Difficulty Conceiving □ Live Births#_____ □ Premature births#_____ □ Miscarriages#_____ Of the live births, were there any problems or complications during the pregnancy or during delivery?
_____ □ Last PAP:_____ □Birth control? What type and for how long_____

□ Fibrocystic breasts □ Yeast infections □ Vaginal dryness

MENSTRUAL CYCLE: □ Age of first menses _____ □ Duration of menses _____ □ Time between menses_____ □ Light flow □ Medium flow □ Heavy flow □ Clotting □ Irregular cycles □ Bleeding between periods □ Spotting □ Cysts □ Endometriosis □ Polyps □ Fibroids

PMS: □ Breast tenderness □ Moodiness □ Cramping □ Bloating/water retention □ Headaches

MENOPAUSE: □ Menopause Age:_____ □ Menopausal Symptoms (please describe):

_____

□ Any other problems with your reproductive system: _____

SLEEP: □ Hard time falling asleep □ Hard time staying asleep □ Insomnia □ Vivid dreams □ Night terrors □ Restless

How many hours of sleep per night do you get?_____ Do you wake feeling rested? (Y / N)

MUSCULOSKELETAL: □ Neck/Upper Back Pain □ Shoulder Pain □ Hip Pain □ Mid Back

Pain □ Arm Pain □ Leg Pain □ Low Back Pain □ Hand/Wrist Pain □ Foot/Ankle Pain □ Joint Pain □ Arhritis _____ Other Problems:_____

WHAT MAKES THE PAIN BETTER: □ Pressure □ Heat □ Cold □ Exercise □ Stretching

QUALITY OF PAIN: □ Sharp □ Dull □ Burning □ Fixed □ Moving □ Achy □ Cramping □ Other:_____

	Lowest								Highest
Pain Level:	1	2	3	4	5	6	7	8	9	10

WHAT MAKES THE PAIN WORSE: □ Pressure □ Heat □ Cold □ Exercise □ Other:_____ □ Does weather affect the pain: Type of weather:_____ □ Any other muscle, joint, or bone problems:_____

NEUROLOGICAL: □ Stroke □ Paralysis □ Numbness/Tingling □ Loss of Balance □ Seizures/Epilepsy □ Dizziness □ Poor Memory □ Any other neurological problems:_____

EMOTIONAL/PSYCHOLOGICAL: □ Anxiety □ Depression □ Bad Temper/irritable □ Panic attacks □ Over-thinker/worry □ Grief/sadness □ Fear □ Easily susceptible to stress □ Bipolar □ Manic depressive □ Have you ever been treated for any mental or emotional conditions:_____ □ Any other emotional issues/ concerns:_____

Comments: Please let me know of any other problems you would like to discuss

_____

_____

_____

_____

Please mark each item below for each sign or symptom you currently have or previously had:
Mark "C" for current Mark "P" for past Current = within the last 3 months

CONSTITUTIONAL
__ Weight Loss
__ Weight Gain
__ Decrease Energy
__ Increase Energy
__ Difficulty Sleeping

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Osteoporosis
__ Joint Replacement
__ Herniated Disc
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Muscle Weakness
__ Sprains/Strains
__ Broken Bones
__ Gout
__ Fibromyalgia
__ Arthritis

CARDIOVASCULAR
__ High Blood Pressure
__ Heart Attack
__ Chest Pain
__ Poor Circulation
__ Heart Disease
__ Irregular Heartbeat
__ Jaw pain
__ Aortic Aneurism
__ Swelling Ankles
__ Varicose Veins
__ High Cholesterol
__ Pacemaker/Defibrillator

EAR/EYE/NOSE/THROAT
__ Ear Noises
__ Dizziness
__ Sore Throat
__ Hearing Loss
__ Nasal Blockage
__ Nose Bleeds
__ Glaucoma
__ Sinusitis
__ Difficulty Swallowing
__ Bleeding Gums
__ Double Vision
__ Blurred Vision

GASTRO-INTESTINAL
__ Bowel Problems
__ Constipation
__ Diarrhea
__ Hemorrhoids
__ Gallbladder Problem
__ Nausea/ Vomiting
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Liver Problems
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Tuberculosis
__ Shortness of Breath
__ Emphysema
__ COPD
__ Cold/Flu
__ Cough/Wheezing

__ Covid 19 / Date:

Have your received your Covid 19

Vaccine? Y/N Date:_____

GENITOURINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Disease
__ Painful Urination
__ Kidney Stone
__ Loss of Bladder Control
__ STD

NEUROLOGIC
__ Stroke
__ Seizures
__ Head Injury
__ Brain Aneurysm
__ Numbness
__ Severe Headaches
__ Pinched Nerves
__ Parkinsons
__ Stiff Joints
__ Carpal Tunnel
__ Spinning/Balance
__ Multiple Sclerosis
__ Migraines

ALLERGIC/IMMUNOLOGIC
__ Hives
__ Immune Disorder
__ HIV/AIDS
__ Allergy Shots
__ Cortisone Use

INTEGUMENTARY
__ Skin Ulcers
__ Skin Disease
__ Eczema
__ Psoriasis
__ Rashes
__ Dryness
__ Sensitive Skin
__ Boils

HEMATOLOGIC/LYMPHATIC
__ Hepatitis
__ Blood Clots
__ Cancer
__ Easy Bruising
__ Easy Bleeding
__ Fevers/Chills/Sweats

PSYCHIATRIC
__ Depression
__ Anxiety Disorder
__ Unusual Stress
__ ADHD
__ Mental Disorder
__ Alcoholism
__ Drug Addiction

ENDOCRINE
__ Diabetes Type I or II
__Thyroid – Hyper or Hypo
__ Hair Loss
__ Excessive Thirst

WOMEN ONLY
__ Difficult Periods
__Hot Flashes
__ Irregular Cycles
__ Breast Pain
__ Lump In Breast
__ Difficulty Becoming Pregnant
__ Pregnancy Complications
__ Pain With Intercourse
__ Pelvic Pain
__ Cramps
__ Birth Control
__ Pregnant At This Time
__ Date Of Last Period Ended
__ Last Gynecologic Exam

MEN ONLY
__ Testicular Pain
__Prostate Problems
__ Difficult Erection
__ Low Sperm Count
__ Pain With Intercourse
__ Pelvic Pain

Have you had any recent: surgeries, trauma, Illness, recent diagnosis or new medications in the past year?

If yes, please explain _____

_____

Name:_____ Date:_____

BP:_____/_____ HR:_____

Height:_____ Weight:_____

mind, body & spirit chiropractic