Allexi Chiropractic and Acupuncture
813 Fox Lane Ste D, Waterford, WI 53185

HEALTH INFORMATION

Patient Name: _____ Date: _____

Have you ever received acupuncture care? □ Yes □ No When? _____
Have you ever received chiropractic care? □ Yes □ No When? _____

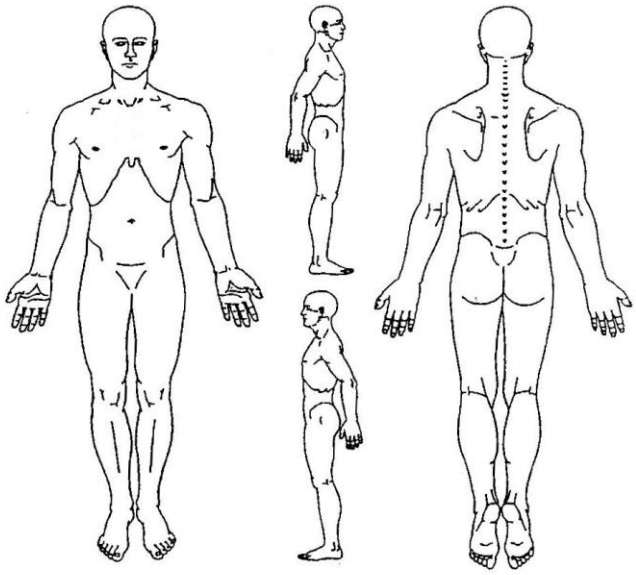
Was previous care for the same reason as today's visit? □ Yes □ No

List your symptoms and when and how they began?

_____
_____
_____
_____

Circle the intensity of your symptoms:

0	1	2	3	4	5	6	7	8	9	10
No Pain →										*Excruciating*



MARK AREAS OF COMPLAINT OR PAIN

Dull: ///

Sharp: XXX

Numb: ~~~

Pins & Needles & Tingling: *

Burning: VVV

Show Radiation of Pain or Tingling or Numbness

How often and what time of day do you experience your symptoms?_____

What makes your symptoms worse?_____

What makes your symptoms better?_____

Why do you think that you are having difficulty?

_____
_____

What do you think you need to feel better?

_____
_____

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List any other care, treatments or medications that you have received for your complaints:

_____

_____

List any labs done and whether the results were positive or negative:

_____

_____

List any surgeries or serious accidents with dates:

_____

_____

Do you or have you ever had any of the following diseases or conditions?

□ HIV / AIDS	□ Cancer	□ Artificial Bones / Joints
□ Tuberculosis	□ Chemotherapy / Radiation	□ Hepatitis A, B or C
□ Shingles	□ Drug Abuse	□ Arthritis
□ Diabetes	□ Pacemaker	□ Fibromyalgia

List any allergens that may have caused anaphylactic reactions and when they happened:

_____

_____

List any other allergies that have been confirmed or suspected and describe your reactions:

_____

_____

_____

List any family health history of complaints or disease and which family member was affected?

_____

_____

Have you ever been treated for an emotional stress problem? _____ When? _____
Are you currently in therapy? _____ Are you prone to depression? _____

Please list any nutritional supplements that you may take:

_____

_____

Do you wear shoe inserts? _____ What is the age of your mattress? _____years old

For Females: Are you pregnant? □ Yes □ No □ Not Sure For how long? _____

Are you nursing? □ Yes □ No

*** During the course of your treatment, it is your responsibility and crucial that you inform Dr. Allexi if there is a possibility that you might be pregnant. It will alter your treatment. ***

Patient Signature: _____ Date: _____

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Please check any symptoms that you have had within the last six months.
Do not check any symptoms that are related to a common cold or flu, unless you are still ill.

GENERAL SYMPTOMS

_____ Headache
_____ Fever
_____ Chills
_____ Night Sweats
_____ Fainting
_____ Dizziness
_____ Seizures
_____ Insomnia
_____ Fatigue
_____ Nervousness
_____ Tumors, Cysts, Boils
_____ Heat Intolerance
_____ Cold Intolerance
_____ Recent Enlargement of Lymph Node
_____ Frequent Colds and Flu
_____ Sudden Weight Loss
_____ Recent Changes in Pigmentation
_____ Flushed Face
_____ Easily Frightened or Jumpy
_____ Often Thirsty
_____ Abnormal Lab Tests
_____ Excessive Sweating
_____ Lack of Perspiration

GASTROINTESTINAL

_____ Poor Appetite
_____ Poor Digestion
_____ Excessive Hunger
_____ Belching
_____ Heartburn
_____ Gas
_____ Nausea
_____ Vomiting
_____ Pain Over Stomach
_____ Diarrhea
_____ Constipation
_____ Colon Trouble
_____ Hemorrhoids/Rectal Pain
_____ Halitosis
_____ Use Laxatives
_____ Bloating/Distension
_____ Use Antacids

CARDIOVASCULAR

_____ Palpitations
_____ Irregular Heartbeat
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Pain Over Heart
_____ Previous Heart Trouble
_____ Swelling of Ankles
_____ Poor Circulation
_____ Varicose Veins
_____ Strokes

RESPIRATORY

_____ Chronic Chest Colds
_____ Chronic Cough
_____ Chest Pain
_____ Excessive Phlegm
_____ Bronchitis
_____ Asthma
_____ Shortness of Breath
_____ Seasonal Allergies
_____ Sinus Infection

EYE • EAR • NOSE • THROAT • MOUTH

_____ Red Eyes
_____ Blurry Vision
_____ Eye Strain
_____ Spots or Floaters
_____ Pain/Pressure in Eyes
_____ Hearing Difficulties
_____ Ringing or Buzzing in Ears
_____ Ear Infections
_____ Lose Balance Easily
_____ Nasal Obstruction
_____ Nose Bleeds
_____ Loss of Sense of Smell
_____ Enlarged Thyroid
_____ Chronic Sore Throat
_____ Grind Teeth
_____ Hoarseness
_____ Unusual Taste in Mouth

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SKIN

_____ **Itching**
_____ **Bruise Easily**
_____ **Dryness**
_____ **Sensitive Skin**
_____ **Hives or Allergic Skin Reaction**
_____ **Eczema**
_____ **Acne**
_____ **Dandruff**

GENITOURINARY

_____ **Frequent Urination**
_____ **Painful Urination**
_____ **Incomplete Voiding of Bladder**
_____ **Blood in Urine**
_____ **Inability to Control Urine**
_____ **Kidney Infection**
_____ **Bladder Infection**
_____ **Bed Wetting**
_____ **Prostate Trouble**
_____ **Loss of Sexual Appetite or Potency**
_____ **Venereal Disease**

EXERCISE

_____ **None** _____ **Moderate**
_____ **Mild** _____ **Daily**
What kind of exercise?
_____

MUSCLES AND JOINTS

_____ **Numbness in Arms or Hands**
_____ **Numbness in Legs or Feet**
_____ **Weakness**
_____ **Twitching**
_____ **Stiff Neck**
_____ **Backache**
_____ **Upper**
_____ **Middle**
_____ **Lower**
_____ **Pain in Arms or Hands**
_____ **Pain in Legs or Feet**
_____ **Swollen/Painful Joints**
_____ **Foot Trouble**
_____ **Hernia**
_____ **Rib Pain**
_____ **Shaking or Trembling**
_____ **Muscle Spasm**

HABITS

_____ **Sugar**	_____ **Amount Day**
_____ **Smoking**	_____ **Packs Day**
_____ **Alcohol**	_____ **Drinks Day**
_____ **Coffee**	_____ **Cups Day**
_____ **Decaf**	_____ **Cups Day**
_____ **Diet Soda**	_____ **Amount Day**
_____ **Reg. Soda**	_____ **Amount Day**
_____ **Caff. Tea**	_____ **Amount Day**

What specific goals would you like to address with Dr. Allexi?

1._____
2._____
3._____
4._____
5._____
6._____

Is there anything else that you would like Dr. Allexi to know?

_____
_____
_____
_____