

Alexi Chiropractic and Acupuncture
811 Fox Lane Ste D, Waterford, WI 53185

HEALTH INFORMATION

Patient Name: _____

Date: _____

Have you ever received acupuncture care? Yes No

When? _____

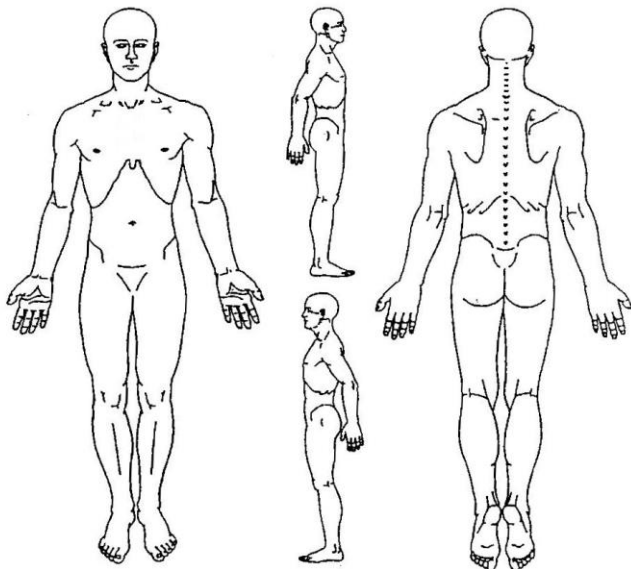
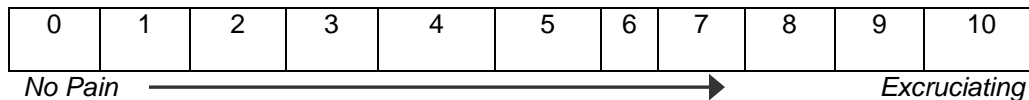
Have you ever received chiropractic care? Yes No

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:



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?

Have you been vaccinated? If Covid, what type and how many? _____ If Flu, how many times? _____

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

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?

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Artificial Bones / Joints |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chemotherapy / Radiation | <input type="checkbox"/> Hepatitis A, B or C |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> 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: _____

Alexi Chiropractic and Acupuncture
811 Fox Lane Ste D, Waterford, WI 53185

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

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

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

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

Alexi Chiropractic and Acupuncture
811 Fox Lane Ste D, Waterford, WI 53185

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?

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

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

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

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

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Sugar | <input type="checkbox"/> Amount Day |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Packs Day |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drinks Day |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Cups Day |
| <input type="checkbox"/> Decaf | <input type="checkbox"/> Cups Day |
| <input type="checkbox"/> Diet Soda | <input type="checkbox"/> Amount Day |
| <input type="checkbox"/> Reg. Soda | <input type="checkbox"/> Amount Day |
| <input type="checkbox"/> Caff. Tea | <input type="checkbox"/> Amount Day |