



Johnson Chiropractic, Acupuncture, and Oriental Medicine, LLC

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* Dr. Heather Johnson, D.O.M. *

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. If you have questions, please ask. Thank you.

Today's Date: _____

Full Legal Name:		Name I prefer to be called:	
Gender: <input type="checkbox"/> male <input type="checkbox"/> female	Date of Birth:	Age:	
Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed			
Main phone #:		Other phone #:	
Email address:		Do you allow us to contact you by email? <input type="checkbox"/> yes <input type="checkbox"/> no	
Emergency contact name and #:			
Address:		City:	State: Zip:
Family Physician:		Chiropractor:	
Do you have health insurance? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what is the name of your company?			
Does your insurance cover acupuncture? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure		Have you ever been treated with acupuncture before? <input type="checkbox"/> yes <input type="checkbox"/> no	
How did you find out about our clinic? <input type="checkbox"/> location <input type="checkbox"/> phone book <input type="checkbox"/> website <input type="checkbox"/> existing patient			
<input type="checkbox"/> friend/relative (name):		<input type="checkbox"/> referred by: <input type="checkbox"/> other:	

Main Problem(s): _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities? (such as work, sleep, sex, household chores, driving?)

What kind of treatment have you tried? _____

What makes this problem worse? _____

What makes this problem better? _____

Is there anyone in your family with the same/similar problem? _____ Has your case been referred to an attorney? yes no

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Breathing Problems			Tuberculosis		
Diabetes			Heart Disease			High Cholesterol		
Hepatitis			Digestive Disorders			High Blood Pressure		
Thyroid Disease			Venereal Disease			Emotional Disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or Anxiety			Infertility		
Asthma			Allergy Symptoms			Irregular Periods		
Stroke			Other:			Dysmenorrhea		
Hypothyroid			Hyperthyroid			Hypoglycemia		
Fibromyalgia			Chronic Fatigue Syndrome					

Do you have any infectious diseases? yes no If yes, explain: _____

Surgeries: _____

Hospitalization: _____

Significant Trauma (auto accidents, sports injuries, etc): _____

Allergy Symptoms (drugs, chemicals, herbs, foods, environmental): _____

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc. and their dosages): _____

Please check if you have or have had (in the last three months) any of the following diseases or conditions:

- Skin and Hair:** rashes ulcerations hives itching eczema pimples
 acne purpura dandruff dry skin recent mole loss of hair brittle/dry hair
 change in hair or skin texture other?

- Musculoskeletal** joint disorders tremors jaw clicks neck pain back pain muscle weakness
 pain/soreness in the muscles hernia knee pain hip pain joint pain swelling of hands/feet
 localized weakness hand pain wrist pain numbness tingling difficult walking
 cold hands/feet joint sprain paralysis shoulder pain neck tightness spinal curvature
 arm pain leg pain other?

- Head, eyes, ears, nose, and throat** dizziness concussions migraines glasses/lens
 eye strain eye pain poor vision cataracts blurry vision night blindness color blindness
 earaches poor hearing ringing in ears sinus problem sore throat nose bleeding spots in front of the eyes
 grinding teeth teeth problems facial pain facial paralysis sores on lips/tongue difficulty swallowing
 glaucoma tearing eye dryness nose bleeds other?

- Cardiovascular** high blood pressure low blood pressure chest pain palpitation/fluttering
 fainting phlebitis varicose veins irregular heart beat rapid heartbeat bleed or bruise easily
 heart disease swelling of ankles stroke heart murmurs rheumatic fever

- Respiratory** cough coughing blood persistent cough flu wheezing
 difficulty breathing bronchitis pneumonia chest pain production of phlegm- what color?

frequent common colds emphysema pleurisy asthma tuberculosis
 shortness of breath Other Respiratory Problems: _____

Gastrointestinal poor appetite change in appetite cravings strong thirst desire for hot food/drink
 desire for cold food/drink weight loss weight gain nausea vomiting diarrhea
 constipation gas belching black stools blood in stools indigestion bad breath
 rectal pain hemorrhoids ulcers parasites ab pain/cramps chronic laxative use
 epigastric pain liver disease hepatitis gallbladder problems
 bowel movements: frequency _____ per day color: _____ odor? yes no

Neuro-Psychological: poor balance lack of coordination concussion depression
 sudden energy drop- What time of day? _____ stress bad temper
 bi-polar swings poor sleep fatigue mental tension mood swings
 nervousness other anxiety

Genito-Urinary painful urination frequent urination blood in urine urgency to urinate kidney stones
 unable to hold urine dribbling pause of flow frequent urinary tract infection genital pain
 genital itching genital rashes STD kidney disease kidney stones
 night time urination? _____ times per night other?

Other: fevers chills night sweats sweat easily chronic infections slow wound healing
Favorite time of year _____ Worst time of year _____

Female: frequent vaginal discharge pelvic infection endometriosis vaginal/genital discharge
 fibroids ovarian cysts irregular periods clots pain/cramps prior to or during period
 hot flashes breast tenderness breast lumps fertility problems moodiness related to periods
 nipple discharge heavy flow light flow
Date of last period _____ Age of first period _____ Duration of periods: _____ days Cycle: _____ days
_____ number of pregnancies _____ # of births _____ # of miscarriages _____ # of abortions
_____ # of premature births _____ # of c-sections _____ # of difficult deliveries

Do you practice birth control? yes no If yes, what type and for how long? _____
If you're on birth control pills, what are you taking and for how long? _____
Do you have any reason to believe that you are pregnant? yes no. If yes, how far along? _____

Male: prostate problems discharge erectile dysfunction ejaculation problems fertility problems
 frequent seminal emission painful/swollen testicles other?

Occupation: _____ Do you usually work indoors outdoors?
Occupational stress (chemicals, physical, psychological, stress level, etc.): _____

Personal: height: _____ weight now: _____ weight one year ago: _____ highest weight and year: _____

Habits: Do you smoke? yes no What? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes: _____

Do you exercise regularly? yes no Please describe your exercise program? _____

How many hours do you sleep per night? _____ What time do you usually go to bed? _____ Do you feel rested? yes no

Diet How much coffee do you drink? _____ cups/day Colas _____ number/day Tea _____ cups/day

What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

How much water do you drink per day? _____ Are you a vegetarian? yes no Do you eat a lot of spicy food? yes no

Do you typically eat three meals a day? yes no. If not, how many? _____

Please describe your average daily diet. Please be as specific as possible:

Morning: _____

Afternoon: _____

Evening: _____

Snacks: _____

Is there anything else we should know? _____

I have completed this form correctly to the best of my knowledge.

Signature:

Please check one of the following: I am an Adult Patient Parent or Guardian Spouse Power of Attorney