CORNERstone
CHIROPRACTIC & WELLNESS
153 South Main Street Shawano, WI 54166

Acupuncture Intake Form

Name: _____ **Age:** _____ **Today's Date:**_____
Mailing Address: _____**City:** _____ **St:** ____ **Zip:** _____
Phone (home): _____ **(cell):**_____ **Preferred Contact: Home / Cell / Either**
SSN#:_____ **Birth date:** ____/____/____ **E-Mail:** _____
I Am: **O Married** **O Single** **O Divorced** **O Partnered** **O Widowed**
Employer: _____ **Occupation:**_____
Emergency Contact/Relationship: _____**Phone:** _____
How did you hear about us? _____

We promise to treat you with respect, compassion, and understanding.

MEDICAL HISTORY

Do you suffer from any of the following: (check all that apply)

- ○ Diabetes
- ○ Arthritis
- ○ Anxiety
- ○ Depression
- ○ Heart Attack
- ○ Asthma
- ○ Migraines
- ○ Chronic Headache
- ○ HIV/AIDS
- ○ MRSA
- ○ Hepatitis
- ○ Auto immune disorder
- ○ Anemia
- ○ Infertility
- ○ Hyper-Thyroid
- ○ Hypo-Thyroid
- ○ Stroke
- ○ IBS
- ○ Cancer
- ○ Allergies
- ○ Stomach ulcer
- ○ GI Bleeding
- ○ Bleeding Disorder
- ○ High Blood Pressure

Please explain any above condition: (example: date diagnosed, by physician etc.)

_____
_____
_____
_____

List any hospitalizations, surgeries, traumas below:

When **Reason**

Please list any prescriptions, over-the-counter medications or supplements you currently take:

Medication/Supplement	Reason	Dosage	Taken since?

Please list all known drug or food (shellfish, nut, diary, gluten, etc.) allergies/intolerances if not already listed above:_____

_____

_____

Main health concern that you are seeking care for today

_____

Severity on a 1-10 scale *(10 being most severe)* **1 2 3 4 5 6 7 8 9 10**

How long have you been experiencing this issue?_____

What, if anything makes it better?_____

_____

_____

What, if anything, makes it worse?_____

_____

_____

Body Temperature:

Overall do you run: **HOT COLD NEUTRAL**

Are you experiencing or have you in the last week experienced a fever with or without chills? **YES NO**

Do you experience spontaneous sweating? **YES NO** If yes where on body?_____

Do you experience night sweats? **YES NO**

Head/Ears:

Do you experience any of the following?

- ○ Headaches
- ○ Migraines
- ○ Poor or decreased hearing
- ○ Dizziness
- ○ Floaters in vision
- ○ Ringing in the ears

Chest/Abdomen:

Do you experience any of the following?

- ○ Wheezing
- ○ Shortness of breath
- ○ Coughing
- ○ Frequent colds
- ○ Seasonal allergies
- ○ Tightness in chest
- ○ Palpitations
- ○ Chest pain

Energy:

Overall rate your energy from 1-10 (10 being high energy) **1 2 3 4 5 6 7 8 9 10**

At what time of day is your energy the highest? _____

Do you drink coffee or other caffeinated beverages? **YES NO**

If yes how much, how often? _____

Mental/Emotional:

Do you experience any of the following?

- ○ Forgetfulness/poor memory
- ○ Trouble staying focused
- ○ Irritability/Anger
- ○ Sad/weepy
- ○ Anxious/Worried
- ○ Racing mind
- ○ Fearful or easily frightened

Rate your stress level on a 1-10 scale (10 is most stressed) **1 2 3 4 5 6 7 8 9 10**

Reasons for stress: _____

_____

Sleep:

Do you experience any of the following?

- ○ Trouble falling asleep
- ○ Trouble staying asleep
- ○ Vivid dreaming
- ○ Nightmares or scary dreams
- ○ Excessive sleep

Do you wake up feeling refreshed? **YES NO**

How many hours per night do you usually sleep? _____

Do you feel **HOT COLD OR NO TEMPERATURE CHANGE** when you sleep?

Musculoskeletal/Extremities:

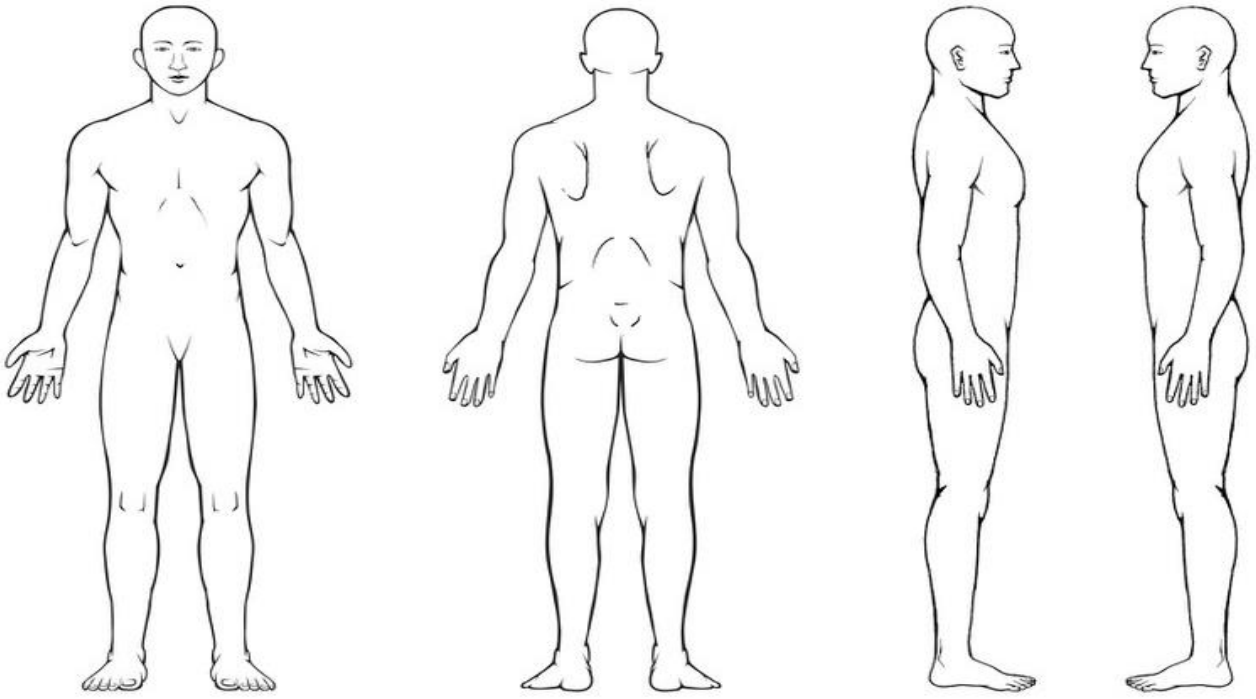
Are you currently experiencing any muscular pain? **YES NO**

Are you currently experiencing any joint pain? **YES NO**

Do you experience any of the following?

- ○ Numbness
- ○ Tingling
- ○ Burning
- ○ Tightness
- ○ Body heaviness
- ○ Cold back or knees
- ○ Tremors
- ○ Spasms
- ○ Swelling
- ○ Aching
- ○ Weakness in back
- ○ Weakness in knees

Please indicate areas where you feel your symptoms:



Digestion/Appetite:

Which best describes your appetite? **EXCESSIVE EATING POOR APPETITE NORMAL**

Do you experience bloating after eating? **YES NO**

Do you experience any cravings? **YES NO** If yes for what food/flavor?_____

Do you experience stomach pain? **YES NO** If yes how often? _____

Please check any/all below that apply:

- ○ Bad breath
- ○ Nausea
- ○ Vomiting
- ○ Loss of taste
- ○ Thirst for cold drinks
- ○ Thirst for hot drinks
- ○ No thirst
- ○ Frequent gas
- ○ Heartburn/reflux
- ○ Frequent belching
- ○ Excessive weight loss/ weight gain _____lbs
- ○ Eating disorder

Do you use any of the following substances? *Cigarettes (vaping included), chewing tobacco, alcohol, recreational drugs*

List substance: How often? How much?

Bowel Movements/Urination:

When you have a bowel movement is it easy to go? **YES NO**

Do you experience constipation? **YES NO** If yes how often?_____

Do you experience diarrhea or loose stool? **YES NO** If yes how often?_____

How many bowel movements do you have per day?_____

Do you experience any of the following with your bowel movements?

- ○ Cramps
- ○ Incomplete feeling after going
- ○ Burning
- ○ Bleeding
- ○ Foul odor
- ○ Mucus in stool
- ○ Sticky stool that is hard to clean (takes more than 1-2 times to wipe)
- ○ Urgency

Generally how many times do you urinate in a day? **1-5 5-10 10-20 20+**

Do you experience any of the following when it comes to urination?

- ○ Dark urine (dark yellow/brown)
- ○ Pale urine (pale yellow/clear)
- ○ Pain or burning with urination
- ○ Urgency
- ○ Incontinence
- ○ Kidney stones
- ○ Cloudy urine
- ○ Blood in urine
- ○ Dribbling after urination
- ○ Difficulty emptying bladder
- ○ Weak urine stream
- ○ Urination that disrupts sleep

Sexual Health:

Do you experience any of the following?

- ○ Low libido
- ○ Genital pain/itching
- ○ Excessive discharge
- ○ Painful intercourse
- ○ Infertility
- ○ STDs

Women

- ○ Recurring yeast infections
- ○ Vaginal dryness
- ○ Fibroids/Cysts
- ○ Breast lumps/nodules
- ○ Endometriosis
- ○ PCOS

Men

- ○ Erectile dysfunction
- ○ Premature ejaculation
- ○ Nocturnal emission
- ○ Enlarged prostate
- ○ Pain or swelling in testicle(s)

Women's Health *(Males can skip these questions)*

*(***if you are in menopause please skip down to the menopause section)*

Menstruation:

Age of first period: _____ I usually bleed for _____ days

There are _____ days between each cycle I am on day _____ of my current cycle

Do you have an irregular cycle? **YES** **NO** If yes what is your cycle range? _____ -_____ days

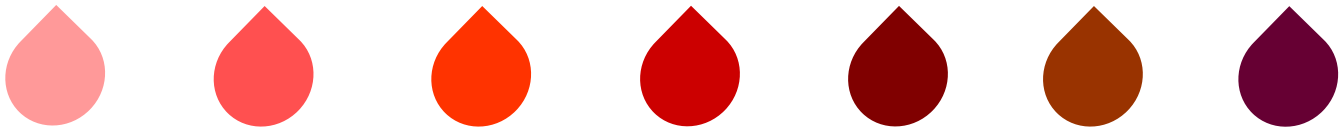
Do you experience spotting before, during , or after your cycle? _____

Please explain the heaviness of your cycle: (*ex: heavy on days 1-3 light on days 4-5)*

_____

_____

Please indicate the color of your blood during your cycle: *(ex: blood is pale red on day1, dark red days 2-3 and dark brown on days 4-5)*



Pale pink Pink Bright red Red Dark red Brown Purple

Do you experience clots with your period? **YES** **NO** If yes what size? **Small** **Med** **Large**

Do you experience any of the flowing during your cycle?

- ○ Dizziness
- ○ Insomnia
- ○ Fatigue
- ○ Acne
- ○ Changes in bowel movements
- ○ Cramps before
- ○ Cramps during
- ○ Bloating
- ○ Breast tenderness
- ○ Headaches
- ○ Nausea
- ○ Food cravings
- ○ Sadness
- ○ Irritability
- ○ Chest pain
- ○ Low back pain

Are you currently using birth control? **YES** **NO** If yes, list type:_____

Are you currently trying to conceive? **YES** **NO**

Are you currently pregnant? **YES** **NO**

Are you currently lactating? **YES** **NO**

How many pregnancies have you had? _____ How many live children do you have?_____

Menopause:

*(****answer questions below only if in menopause)*

Are you peri-menopausal? **YES** **NO** If yes date of last bleed:_____

Are you post-menopausal *(have not menstruated for at least 12 months)*? **YES** **NO** since:_____

Have you ever had a hysterectomy? If yes please list date and what was removed:

Reason for hysterectomy:_____

If any, how many pregnancies have you had? _____ How many live children do you have?_____

Do you experience hot flashes? **YES** **NO** If yes how often?_____