Patient Name: _____
Patient ID#: _____
Today's Date: _____

Wenger Chiropractic Group
ACUPUNCTURE PATIENT QUESTIONNAIRE

Main complaint, injury or illness: _____ Began On: _____

Describe what causes it: _____ What makes it better / worse: _____

Does/ Do the symptom(s) interfere with: ☐ Work ☐ Sleep ☐ Other Explain: _____

Have you ever consulted a physician about your present symptom(s) ☐ Yes ☐ No

Please describe outcome in detail: _____

Other complaints: _____

PREVIOUS MEDICAL CARE
Have you ever been hospitalized: ☐ Yes ☐ No Surgeries: ☐ Yes ☐ No

Describe surgeries and list dates: _____

Please list the medications you take: _____

_____

Have you ever been involved in an automobile accident: ☐ Yes ☐ No If so, when: _____

Treatment for other conditions: _____

Personal History: Please check all that pertain to you
☐ Heart Disease ☐ Hypertension ☐ Anemia ☐ Diabetes ☐ Hepatitis ☐ Hay Fever ☐ Scarlet Fever ☐ TB
☐ Pneumonia ☐ Asthma ☐ Rheumatic Fever ☐ Polio ☐ HIV ☐ Syphilis ☐ Gonorrhea ☐ Epilepsy
☐ Bladder Disease ☐ Meningitis ☐ Miscarriage ☐ Pleurisy ☐ Mental Disorder ☐ Gallbladder Disease
☐ Rectal Disease ☐ Alcoholism ☐ Drug Abuse ☐ Kidney Disease ☐ Boils / Infection ☐ Nerve Breakdown
☐ Others: _____

Family History: Please check the following pertaining to what your parents may have had
☐ Cancer ☐ Stroke ☐ Hypertension ☐ Diabetes ☐ Scoliosis ☐ Kidney Disease ☐ Headaches ☐ Ulcers
☐ Asthma ☐ Glaucoma ☐ TB ☐ Epilepsy ☐ Allergies ☐ Arthritis ☐ Alcoholism ☐ Mental Disorder ☐ Drug Abuse
☐ Others: _____

Injuries: Please check the following
☐ Fracture ☐ Dislocations ☐ Sprain ☐ Concussion / Head Injury ☐ Loss of Consciousness

Name: _____ Date: _____

Please place a check in the box next to the current conditions. Circle conditions you have had in the past. Please provide the date, duration, frequency and intensity of pain for any conditions checked or circled.

General Symptoms

- [ ] Tremors
- [ ] Headache
- [ ] Fever
- [ ] Sweats
- [ ] Fainting
- [ ] Dizziness
- [ ] Convulsions
- [ ] Insomnia
- [ ] Fatigue
- [ ] Nervousness
- [ ] Depression
- [ ] Loss of weight
- [ ] Forgetfulness
- [ ] Confusion
- [ ] Numbness or pain in arms, hands, elbows, shoulder, shoulders, hips, legs, knees or feet
- [ ] Paralysis

Eyes, Ears, Nose & Throat

- [ ] Blurred vision
- [ ] Eye pain
- [ ] Eye strain
- [ ] Cross eyed
- [ ] Eye congestion
- [ ] Glaucoma
- [ ] Ear pain or stuffy
- [ ] Deafness
- [ ] Ear discharge
- [ ] Ear noises, tinnitus
- [ ] Nose bleeds
- [ ] Nasal obstruction
- [ ] Nasal drainage
- [ ] Loss of smell
- [ ] Sinus infection
- [ ] Allergies, easy sneezing
- [ ] Sore throat
- [ ] Hoarseness
- [ ] Difficult speech
- [ ] Difficult swallowing
- [ ] Loss of taste
- [ ] Change in tastes
  - [ ] Dental decay
  - [ ] Gum troubles
  - [ ] Tonsillitis
  - [ ] Enlarged thyroid
  - [ ] Enlarged glands

Skin

- [ ] Skin eruptions
- [ ] Clammy skin
- [ ] Dryness
- [ ] Bruises easily
- [ ] Boils
- [ ] Rashes
- [ ] Sensitive Skin
- [ ] Hives or allergy

Respiratory

- [ ] Frequent colds
- [ ] Chronic cough
- [ ] Spitting up phlegm
- [ ] Spitting up blood
- [ ] Chest pain
- [ ] Difficult breathing
- [ ] Wheezing

Cardio-vascular

- [ ] Rapid beating pulse
- [ ] Slow beating pulse
- [ ] Irregular beating pulse
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Pain over heart
- [ ] Previous heart strokes
- [ ] Hardening of arteries
- [ ] Swelling of ankles
- [ ] Poor circulation
- [ ] Varicose veins

Gastrointestinal

- [ ] Poor appetite
- [ ] Excessive hunger
- [ ] Difficult chewing
- [ ] Belching
- [ ] Nausea
- [ ] Gas
- [ ] Vomiting
- [ ] Vomiting of blood
- [ ] Gastric pain
- [ ] Distention of abdomen
- [ ] Constipation
- [ ] Diarrhea
- [ ] Black stool
- [ ] Blood in stool
- [ ] Colon trouble
- [ ] Hemorrhoids, Piles
- [ ] Parasite
- [ ] Pain in the ribs and hypochondrium
- [ ] Gall bladder stone
- [ ] Jaundice
- [ ] Overweight

Muscle and Joints

- [ ] Stiff neck
- [ ] Bone spur
- [ ] Foot trouble
- [ ] Herniated disc
- [ ] Lower back pain
- [ ] Spinal scoliosis
- [ ] Faulty posture
- [ ] Swollen joints
- [ ] Stiff joints
- [ ] Painful joints
- [ ] Sore muscles
- [ ] Weak muscles
- [ ] Walking problems
- [ ] Sciatica

Urinary

- [ ] Frequent urination
- [ ] Scanty urine
- [ ] Painful urination
- [ ] Blood in urine
- [ ] Foul smelling urine
- [ ] Discolored urine
- [ ] Pus in urine
- [ ] Kidney infection or stone
- [ ] Bed wetting
- [ ] Inability to control urine
- [ ] Prostate trouble

Female

- [ ] PMS
- [ ] Painful menstrual periods
- [ ] Excessive flow
- [ ] Irregular cycle
- [ ] Cramps or back pain
- [ ] Previous miscarriage
- [ ] Vaginal discharge
- [ ] Vaginal pain
- [ ] Congested breast
- [ ] Breast pain
- [ ] Lumps in breast
- [ ] Menopausal symptoms
- [ ] Hot flashes
- [ ] Abnormal bleeding
- [ ] Reduced sexual activity
- [ ] Pregnancy complications

Male

- [ ] Pain associated w/ genit
- [ ] Reduced sexual activity
- [ ] Premature ejaculation
- [ ] Seminal emission
- [ ] Impotence
- [ ] Discharges

Signature: _____ Date: _____

Name: _____ Date: _____

Date of last physical: _____ Doctor: _____

Results of the physical [indicate any problems] : _____

_____

Habits: Please check the boxes to the amount of activity listed. If significant, please comment.

	Heavy	Moderate	Light	None
Alcohol	[ ]	[ ]	[ ]	[ ]
Coffee	[ ]	[ ]	[ ]	[ ]
Tea	[ ]	[ ]	[ ]	[ ]
Tobacco	[ ]	[ ]	[ ]	[ ]
Salt	[ ]	[ ]	[ ]	[ ]
Sugar	[ ]	[ ]	[ ]	[ ]
Diet	[ ]	[ ]	[ ]	[ ]
Exercise	[ ]	[ ]	[ ]	[ ]
Other	[ ]	[ ]	[ ]	[ ]

Are you now on [or have you undertaken] a restricted diet? Please describe: _____

_____

Vitamins [Taken within the last 2 months]: _____

_____

Medicines [Taken within the last 2 months, including over the counter / herbs]: _____

_____

Allergies [Drugs, Chemical, Foods, Pollen, Type of Reaction]: _____

_____

Wenger Chiropractic Group

PATIENT INFORMATION

Patient ID# (office use): _____ Today's Date: _____

First name _____ M.I. _____ Last Name _____ Nick Name _____

Address _____ City _____ State _____ Zip Code _____

Social Security # _____ Gender: Male/Female Primary Language _____ Date of Birth _____

Email: _____

Marital Status: [ ]Single[ ]Married[ ]Widowed[ ]Divorced[ ]Legally Separated Spouse Name: _____

Race: (Choose most appropriate)
[ ] White [ ] African American or Black [ ] Asian [ ] Hawaiian or Pacific Islander
[ ] American Indian or Alaska native [ ] Decline to specify

Ethnicity: (Choose most Appropriate)
[ ] Not Hispanic or Latino [ ] Hispanic or Latino [ ] Decline to Specify

Contact preference for appointment reminders:

[ ] **Text Message Preferred** _____ [ ] Phone Call _____
CELL PHONE Cell / Home /Work Phone

[ ] Do Not Contact for Appointment Reminders

Emergency Contact Name _____ Phone Number _____ Family Doctor Name _____ Family Doctor Office _____

Primary Insurance _____ Member ID _____ Group Number _____

Primary Insured Name _____ Employer Name _____ HSA / HRA / Neither

Who Referred You To Us? [ ] Physician [ ] Patient [ ] Insurance (define 1)
[ ] Internet (define 2) [ ] Office Sign
Referral Name _____