DEVEREUX CHIROPRACTIC AND ACUPUNCTURE, L.L.C.

Name:_____ Today's Date_____
Date of birth_____ Age_____ Place of employment_____
Address_____ Business phone #_____
City/State_____ Occupation_____
Zip code_____ Insurance_____
Phone_____ Cell_____ e-mail_____
Marital Status S M D W Number of children_____ Number of births_____
Contact in case of emergency_____ Relationship_____ Contacts phone #_____
Name of primary care physician?_____ Date of last physical exam?_____
Have you sought care for a health condition in the past year? Y N if yes, what condition_____
What was the name of the doctor seen?_____ What was the mode of treatment?_____
Have you been to a chiropractor before? Y N When?, Why?, Who?_____
Have you had acupuncture before? Y N When?, Why?, by whom?_____
How did you hear about the practice?_____

Reason for this visit?_____

Have you ever had any of the following conditions? If so, when, which conditions, doctors seen and treatment received.
Cancer Y N _____
HIV/ AIDS Y N _____
Diabetes Y N _____
Hepatitis Y N_____
Epstein Barr Virus/ Mononucleosis Y N _____
Stroke Y N _____
Neurological/muscular diseases: MS, Muscular dystrophy etc. Y N_____
Epilepsy Y N _____
Visual problems/eye diseases Y N _____
Hearing problems/ear diseases Y N _____
Thyroid problems Y N _____
Anemia /blood disorder Y N _____
Autoimmune disorder Y N _____
Heart/vascular disease Y N _____
Blood pressure problems Y N_____
Elevated blood lipids/cholesterol Y N _____
Stomach/digestive problems/ulcers Y N _____
Intestinal/colon problems Y N _____
Lung disease/emphysema/asthma Y N _____
Liver/Gallbladder problems Y N _____
Pancreas/Spleen problems Y N _____
Kidney/Bladder problems Y N _____
Bone disease/osteoporosis Y N _____
Arthritis/Rheumatoid arthritis Y N _____
Allergies/Sinus problems Y N_____
Skin/Nail/Hair conditions: acne, eczema, psoriasis, fungal Y N _____
Sexually transmitted diseases Y N _____
Broken bones/fractures Y N if yes, which one(s)_____
Other condition not listed Y N _____
Is there a family history of any of the above diseases? Y N if yes, which disease and which family member?
_____
Have you ever had any surgeries/hospitalizations? Y N if yes, when?, why?_____
_____
Have been involved in any accidents in the past? Y N if yes, when where any injuries?_____
_____
List any medications you are currently taking and why?_____
List any vitamins/minerals/supplements you are taking and why?_____
Habits: Smoker: Y / N _____#packs/day, Alcohol: Y / N _____#drinks/day or week, Coffee/tea: Y / N _____#cups per day
Soda: Y / N _____#per day, Water:_____#glasses per day, Exercise Y / N type:_____ How often_____
How many bowel movements do you have_____ per day / week. Are the bowel habits: constipated / loose / normal.
How many times do you urinate per day _____. Is it painful Y / N Do you wear orthotics? Y / N
Is there anything you want to tell the doctor Y / N_____

By signing below I certify that I have answered the above questions truthfully and have consented to treatment
Patient/Parent/Guardian_____ Date_____

******CONFIDENTIAL HEALTH INFORMATION******

REVIEW OF SYSTEMS

Place a **0=** if you ***never*** had the symptom, **1**=if you ***previously*** had the symptom, **2=** if you ***currently*** have the symptom.

GENERAL

1._____Frequent infections
2._____Fever
3._____Chills
4._____Night sweats
5._____Loss of sleep
6._____Fatigue
7._____Hot flashes
8._____High stress level
9._____Bleeding problems
10._____Cancer
11._____Diabetes
12._____Weight loss
13._____Weight gain
14._____Inability to gain weight
15._____Allergies

EENT

16._____Vision problems
17._____Pain in the eye(s)
18._____Ear/hearing problems
19._____Ear pain
20._____Ear noises
21._____Nose problems
22._____Nose pain
23._____Sinus problems
24._____Dental problems
25._____Sore gums
26._____Sore throat
27._____Hoarsness
28._____Difficulty with speech
29._____Difficulty swallowing
30._____Thyroid problems

GASTROINTESTINAL

31._____Poor appetite
32._____Excessive appetite
33._____Belching
34._____Frequent nausea
35._____Vomiting food
36._____Vomiting blood
37._____Pain over abdomen
38._____Ulcer
39._____Black or bloody stools
40._____Liver problems
41._____Gallbladder problems
42._____Jaundice
43._____Hernia
44._____Diarrhea
45._____Constipation
46._____Hemorroids
47._____Appendicitis
48._____Intestinal bloating/gas/colic
49._____Intestinal/colon disease

INTEGUMENT

50._____Acne
51._____Itching
52._____Bruise easily
53._____Dry skin
54._____Oily skin
55._____Hair/scalp problems/dandruff
56._____Boils
57._____Hives
58._____Eczema/psoriasis
59._____Nail problems
60._____Skin cancer
61._____Changes in mole(s)

CARDIORESPIRATORY

62._____Lung problems
63._____Difficulty breathing
64._____Chronic cough
65._____Coughing blood
66._____Chest pain
67._____Phlegm
68._____Wheezing
69._____Asthma
70._____Pneumonia
71._____Heart problems
72._____Swelling of ankles
73._____Irregular heart beat
74._____Stroke
75._____Blood pressure problems
76._____Varicose veins
77._____Rheumatic fever

GENITOURINARY

78._____Frequent urination
79._____Scanty urination
80._____Painful urination
81._____Discolored or bloody urine
82._____Bed wetting
83._____Incontinence-urine leakage
84._____Bladder infections
85._____Kidney infections
86._____Kidney stones
87._____Kidney disease
88._____Get up at night to urinate
89._____Venereal disease
90._____Sexual difficulties

NEUROMUSCULOSKELETAL

91._____Scoliosis/spinal curvature
92._____Neck problems/stiffness
93._____Pain between the shoulders
94._____Low back/hip problems
95._____Shoulder/arm/wrist problems
96._____Leg problems
97._____Knee problems
98._____Foot / ankle problems
99._____Joint pain
100._____Swollen joints
101._____Stiff joints
102._____Muscle aches / pain
103._____Muscle weakness
104._____Muscle twitching
105._____Paralysis
106._____Walking problems
107._____Numbness / loss of feeling
108._____Convulsions / seizures
109._____Dizziness / vertigo
110._____Fainting
111._____Forgetfulness / confusion
112._____Hyperactivity
113._____Depression
114._____Mental disorder
115._____Headaches
116._____Broken bones
117._____Disc problems

MEN

118._____Testicular lump / swelling
119._____Testicular pain
120._____Prostate problems
121._____Breast pain
122._____Lump breast
123._____Infertility

WOMEN

124._____Painful menstruation
125._____Irregular cycles
126._____Excessive flow
127._____Scanty flow
128._____Vaginal discharge / burning
129._____Breast pain
130._____Lump in breast
131._____Premestrual syndrome
132._____Menopausal symptoms
133._____Infertility
134._____Miscarriage
135._____Number opreganancies_____
136._____Number of children_____
137._____Are you pregnant? Yes / No

_____ _____

Patient/Parent/Guardian Signature Date

ROS

Patient's name:_____

Item #

Dr.'s intitials_____

HEALTH EVALUATION INDICATORS

Name_____ **Date**_____

Rate statements (0-3) on how they apply to you. 0=Never 1=Mild 2=Moderate 3=Severe

Section 1 _____

A. _____Indigestion 15 min. – 1hr. after eating
_____Excessive belching
_____Sense of fullness after a meal
_____Bad breath (halitosis)
_____Eating high protein foods (meat, fish, soy etc.) causes abdominal gas/cramping/bloating
_____Gas immediately following a meal

B. _____Abdominal bloating/gas/cramping 2-4 hrs. after eating
_____Frequent loose stools or diarrhea
_____Carbohydrates/dairy/sugars cause abdominal bloating/ gas/cramping
_____Tendency towards allergies

C. _____Tendency towards constipation (having less than one bowel movement per day)
_____Stools dry, hard to pass
_____Excessive lower bowel gas
_____Stools alternate constipated / loose
_____Feeling that bowels do not empty completely

Have used antibiotics/sulfa drugs past/present? Yes / No
Have a known gluten intolerance or family history of Yes / No

_____Acid reflux
_____Frequent use of antacids
_____Feeling hungry an hour or two after eating
_____Heartburn when lying down or bending forward
_____Burning sensations in stomach relieved by eating food, milk, carbonated beverages
_____Digestive problems subside with rest and relaxation
_____Heartburn due to spicy foods, chocolate, citrus, alcohol, caffeine

Section 2 _____

_____Abdominal pain/nausea/bloating after eating fatty foods
_____Headaches especially in temple and forehead area
_____Pain between shoulder blades and/or right shoulder
_____Bitter/metallic taste in the mouth
_____Dry/Itchy skin
_____Muscle aches <u>not</u> due to exercise
_____Light colored stools
_____Bowel movements difficult/laxatives used often
_____General feeling of poor health
_____Frequent sneezing

History of gallbladder problems? Yes / No
History of elevated blood lipids/cholesterol? Yes / No

Section 3 _____

_____Feeling exhausted with minimal exertion
_____Shortness of breath with minimal exertion
_____Tendency to be anemic
_____Hands and feet feel cold
_____Bruise easily / gums bleed
_____Frequent nose bleeds
_____Hemorrhoids and / or varicose veins
_____Muscle cramps worse with exercise
_____Irregular heart beat/arrhythmia
_____Swelling of ankles worse at night

History of cardiovascular disease? Yes / No

Section 4 _____

A. _____Feel cold / chilled when others don't (even in warm weather)
_____Weight gain-without increase in appetite
_____Constipation
_____Dry, scaly skin / coarse hair that fall out
_____Mental "sluggishness"
_____Ringing in the ears
_____Numbness and tingling of hands and feet
_____Feel tired / sleepy during the day
_____Dull headaches-especially in the morning wearing off by midday
_____General muscle weakness
_____Reduced initiative to do things
_____Decreased sex drive (men)
_____Menstrual disorders-prolonged heavy bleeding (women)

B. _____Feeling jittery/nervous
_____Inability to sleep well
_____Difficulty gaining weight - even with a large appetite
_____Intolerant to heat
_____Racing pulse at rest
_____Skin feels warm and moist
_____Flush easily
_____Can't work under pressure

History of hypothyroidism? Yes / No
History of hyperthyroidism? Yes / No

Section 5 _____

A.

_____General feeling of exhaustion / fatigue
_____Have respiratory disorders-asthma, bronchitis
_____Like salty foods /crave salt
_____Arthritic tendencies
_____Cannot stay asleep
_____Afternoon headaches
_____Have allergies/catch infections easily
_____Hot flashes
_____Swollen ankles
_____Light headed when standing from a kneeling or sitting position
_____Slow starter in the morning
_____Symptoms are worse under stress
_____Lingering fatigue after exercise
_____Slow to recover after cold / flu
_____Reduced ability to handle stress
_____Afternoon fatigue

History of low blood pressure? Yes / No

B.

_____Difficulty falling asleep
_____Prespire easily with or without activity
_____Gain weight when under stress
_____Under high amounts of stress
_____Awaken tired even after a full nights sleep

History of high blood pressure? Yes / No

Section 6 _____

A.

_____Headaches between meals or if meals are missed
_____Headaches upon rising in the morning better after eating
_____Feel tired/shaky/light headed if meals are missed
_____Eat when stressed
_____Easily agitated, nervous, upset
_____Eating relieves fatigue
_____Feel hungry constantly - even shortly after eating
_____Crave sweets during the day
_____Awaken after a few hours of sleep then hard getting back to sleep
_____Feel moody/irritable when hungry
_____Blurred vision _____Poor memory, forgetful
_____Depend on stimulates (coffee, chocolate etc.) to keep going

History of hypoglycemia or low blood sugar? Yes / No

B.

_____Fatigue after meals _____Must have sweets after meals _____Eating sweets does not relieve cravings for sweets
_____Difficulty losing weight _____Frequent urination _____Increased thirst and appetite
_____Waist girth is equal or larger than hip girth History of hyperglycemia or diabetes? Yes / No

Section 7 _____

_____Frequent colds/infections lasting longer than 1 week
_____Colds/infections settle into the ears, nose, throat, sinuses
_____Sinus congestion
_____Yellow/green nasal discharge
_____Clear, watery nasal discharge
_____Frequent swollen lymph nodes
_____Frequent sore throat
_____Colds/infections settle into lungs
_____Dry cough
_____Productive cough-phlegm, mucus
_____Wheezing
_____Hot/itchy/watery eyes
_____Post nasal drip
_____Tendency to be a mouth breather
_____Dark circles under eyes
_____Hives
_____Dry eyes, nasal passages and / or skin
_____Skin conditions: acne/boils
_____Wounds heal slowly
_____Rashes

Section 8 _____

_____Loss of urine when you cough, sneeze or lift something _____Constant urge to urinate _____Bladder infections _____Bedwetting

Section 9

_____Diminished sex drive _____Menstrual disorder or lack of menstruation _____Increased ability to eat sugar without symptoms

Section 10

_____Increased sex drive _____Tolerance to sugars reduced _____"Splitting" type headaches

Section 11 - Females (menstruating only) _____

Are you perimenopausal? Yes No Alternating menstrual cycle lengths? Yes No
Extended menstrual cycle, greater than 32 days? Yes No Shortened menstrual cycle, less than every 24 days? Yes No

_____Premenstrual tension
_____Painful menses
_____Heavy blood flow
_____Hair loss/thinning
_____Menstrual headaches
_____Acne worse at menses
_____Feeling moody / Sad during menses
_____Scanty blood flow
_____Vaginal discharge
_____Breast tenderness around menses
_____Facial hair growth
_____Ovulation headaches – 2 weeks prior menses
_____Decreased sex drive
_____Infertility
_____Vaginal dryness

Hysterectomy Yes / No Ovaries removed Yes / No

Section 12 – Females (Menopausal females only)

How many years have you been menopausal? _____ Since menopause, do you ever have uterine bleeding? Yes No

_____Hot flashes _____Mental fogginess _____Disinterest in sex _____Mood swings _____Depression
_____Painful intercourse _____Decrease in breast size _____Facial hair growth _____Acne
_____Increased vaginal pain, dryness or itching Hysterectomy Yes / No Ovaries removed Yes / No

Section 13 - Males only _____

A. _____Prostate trouble _____Frequent urination at night _____Urination difficult or dribbling

B. _____Decreased sex drive _____Decreased spontaneous morning erections _____Decreased in fullness of erections
_____Difficulty maintaining erections _____Spells of mental fatigue _____Inability to concentrate
_____Episodes of depression _____Muscle soreness _____Decreased physical stamina
_____Unexplained weight gain _____Increased fat distribution around chest and hips _____Sweating attacks
_____More emotional than in the past _____Infertility

Section 14

Are you on any medications/over the counter remedies? Y / N if yes, list them_____
Are you taking any nutritional supplements? Y / N if yes, list them_____
Do you exercise? Y / N if yes, what type of exercise_____ and how often_____
How many hours a night do you sleep? _____ List any sleeping difficulties_____
How many bowel movements do you have per day? _____ if less than 1 per day, how many per week?_____
How many times per day do you urinate? _____
How many 8 oz. servings of water do you drink per day? _____ Do you have a water filter? Y / N What kind?_____
Are you on any kind of special diet: vegetarian, high protein, low fat etc. if yes, explain? Y / N _____
How many servings per day / week do you consume of the following:

___Green leafy vegetables day / week ___Yellow/orange vegetables day / week ___Fruits day / week ___Nuts day / week
___Grains day / week ___Dairy day / week ___Red meat day / week ___Poultry day / week ___Fish day / week
___Eggs day / week ___Sweets day / week ___Alcohol day / week ___Coffee/tea/caffeine day / week ___Soda day / week
How many meals per day do you typically eat: ___3 meals ___2 meals ___1 meal ____eat frequent small meals ____eat on the run

List up to 4 areas you would like to see improvements in your health.

1._____ 2._____ 3._____ 4._____

Patient's/Parent/Guardian Signature_____ Date:_____

DEVEREUX CHIROPRACTIC AND ACUPUNCTURE, L.L.C.
SYMPTOM SURVEY

Name_____ Date_____

Rate the symptoms 0-10. 0=No problem 10=Severe problem

Chills	0	1	2	3	4	5	6	7	8	9	10
Hot flashes	0	1	2	3	4	5	6	7	8	9	10
Night sweats	0	1	2	3	4	5	6	7	8	9	10
Insomnia	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Dizziness	0	1	2	3	4	5	6	7	8	9	10
Frequent infections	0	1	2	3	4	5	6	7	8	9	10
Indigestion/heart burn	0	1	2	3	4	5	6	7	8	9	10
Belching	0	1	2	3	4	5	6	7	8	9	10
Frequent nausea	0	1	2	3	4	5	6	7	8	9	10
Intestinal bloating	0	1	2	3	4	5	6	7	8	9	10
Diarrhea	0	1	2	3	4	5	6	7	8	9	10
Constipation	0	1	2	3	4	5	6	7	8	9	10
Bowel pain/colic	0	1	2	3	4	5	6	7	8	9	10
Lower bowel gas	0	1	2	3	4	5	6	7	8	9	10
Cough	0	1	2	3	4	5	6	7	8	9	10
Wheezing	0	1	2	3	4	5	6	7	8	9	10
Shortness of breath	0	1	2	3	4	5	6	7	8	9	10
Spitting of phlegm	0	1	2	3	4	5	6	7	8	9	10
Heart palpitations	0	1	2	3	4	5	6	7	8	9	10
Racing heart	0	1	2	3	4	5	6	7	8	9	10
Swollen ankles/edema	0	1	2	3	4	5	6	7	8	9	10
Hot/itchy/watery eyes	0	1	2	3	4	5	6	7	8	9	10
Dry eyes	0	1	2	3	4	5	6	7	8	9	10
Blurred vision	0	1	2	3	4	5	6	7	8	9	10
Sore throat	0	1	2	3	4	5	6	7	8	9	10
Itchy throat	0	1	2	3	4	5	6	7	8	9	10
Sinus pain	0	1	2	3	4	5	6	7	8	9	10
Nasal discharge	0	1	2	3	4	5	6	7	8	9	10
Stuffy nose	0	1	2	3	4	5	6	7	8	9	10
Postnasal drip	0	1	2	3	4	5	6	7	8	9	10
Hoarseness	0	1	2	3	4	5	6	7	8	9	10
Frequent sneezing	0	1	2	3	4	5	6	7	8	9	10
Ear aches/pain	0	1	2	3	4	5	6	7	8	9	10
Ear noises	0	1	2	3	4	5	6	7	8	9	10
Anxiety/ nervousness	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Hyperactivity	0	1	2	3	4	5	6	7	8	9	10
Feeling stressed	0	1	2	3	4	5	6	7	8	9	10
Lack of concentration	0	1	2	3	4	5	6	7	8	9	10
Excessive perspiration	0	1	2	3	4	5	6	7	8	9	10
Bruise easily	0	1	2	3	4	5	6	7	8	9	10

Dark circles under eyes	0	1	2	3	4	5	6	7	8	9	10
Dry/itchy skin	0	1	2	3	4	5	6	7	8	9	10
Blemishes/acne	0	1	2	3	4	5	6	7	8	9	10
Rashes/hives	0	1	2	3	4	5	6	7	8	9	10
Brittle/nail problems	0	1	2	3	4	5	6	7	8	9	10
Muscled twitching	0	1	2	3	4	5	6	7	8	9	10
Muscle weakness	0	1	2	3	4	5	6	7	8	9	10
Muscle aches	0	1	2	3	4	5	6	7	8	9	10
Muscle cramps	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Neck pain	0	1	2	3	4	5	6	7	8	9	10
Shoulder pain	0	1	2	3	4	5	6	7	8	9	10
Upper back pain	0	1	2	3	4	5	6	7	8	9	10
Lower back pain	0	1	2	3	4	5	6	7	8	9	10
Hip pain	0	1	2	3	4	5	6	7	8	9	10
Leg pain	0	1	2	3	4	5	6	7	8	9	10
Knee pain	0	1	2	3	4	5	6	7	8	9	10
Ankle pain	0	1	2	3	4	5	6	7	8	9	10
Foot pain	0	1	2	3	4	5	6	7	8	9	10
Arm pain	0	1	2	3	4	5	6	7	8	9	10
Elbow pain	0	1	2	3	4	5	6	7	8	9	10
Wrist pain	0	1	2	3	4	5	6	7	8	9	10
Hand pain	0	1	2	3	4	5	6	7	8	9	10
Painful joints	0	1	2	3	4	5	6	7	8	9	10
Stiff joints	0	1	2	3	4	5	6	7	8	9	10
Swollen joints	0	1	2	3	4	5	6	7	8	9	10
TMJ/jaw problems	0	1	2	3	4	5	6	7	8	9	10
Frequent urination	0	1	2	3	4	5	6	7	8	9	10
Incontinence	0	1	2	3	4	5	6	7	8	9	10
Bed-wetting	0	1	2	3	4	5	6	7	8	9	10
Females:											
Painful menstruation	0	1	2	3	4	5	6	7	8	9	10
Excessive flow	0	1	2	3	4	5	6	7	8	9	10
Scanty flow	0	1	2	3	4	5	6	7	8	9	10
PMS	0	1	2	3	4	5	6	7	8	9	10
Premenstrual headaches	0	1	2	3	4	5	6	7	8	9	10
Menopausal symptoms	0	1	2	3	4	5	6	7	8	9	10
Male:											
Prostate problems	0	1	2	3	4	5	6	7	8	9	10
Others:											
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10

Rate your ability to currently perform the following tasks (check which apply):

Lying: ___normal ___limited ___difficult ___painful
Standing: ___normal ___limited ___difficult ___painful
Bending: ___normal ___limited ___difficult ___painful
Walking stairs: ___normal ___limited ___difficult ___painful
Dressing yourself:___normal ___limited ___difficult ___painful
Preparing meals: ___normal ___limited ___difficult ___painful

Sitting: ___normal ___limited ___difficult ___painful
Walking: ___ normal ___limited ___difficult ___painful
Lifting: ___normal ___limited ___difficult ___painful
Bathing: ___normal ___limited ___difficult ___painful
Cleaning house: ___normal ___limited ___difficult __painful

List up to four areas in your health that you would like to see improvements:

1._____ 2._____ 3._____ 4._____

Patient/Parent/Guardian Signature_____ Date_____