Pulley Chiropractic & Acupuncture, LLC
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New Patient Intake

About You

Last Name _____ First Name _____ MI ___ Suffix ___

I would prefer to be called _____

Mailing Address _____

City _____ State _____ Zip _____

E-mail _____

Phone (H) _____ (W) _____ (C) _____

The best time to reach me ☐ Morning ☐ Afternoon ☐ Evening ☐ Any

Please sign me up for automatic appointment reminders via ☐ Email ☐ Text

If signing up for text reminders, my cell phone carrier is _____

Any additional contact instructions _____

Date of Birth ____ / ____ / _____ Social Security Number _____

Sex: ☐ M ☐ F

Marital Status ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Number of Children & Ages _____

Employment Status ☐ Full-time ☐ Part-time ☐ Not employed ☐ Student

Occupation(s) _____

Place(s) of Employment _____

Emergency Contact _____

Relationship to You _____ Phone _____

Who referred you to Pulley Chiropractic & Acupuncture? ☐ Web search ☐ Saw the sign

☐ Met Dr. Pulley ☐ Referred by _____

Reason(s) for Today's Visit

☐ Wellness / Prevention ☐ Symptom Relief ☐ Auto Accident ☐ Other _____

Previous chiropractic care? ☐ Yes ☐ No Chiropractor's Name _____

Previous acupuncture treatment? ☐ Yes ☐ No Acupuncturist's Name _____

Primary Care Physician (PCP)? ☐ Yes ☐ No PCP's Name _____

Family Health History

Please describe your family members' current health (please list any major illnesses):

Mother's health _____ Living Deceased

Father's health _____ Living Deceased

Siblings?

Brother's / sister's health _____ Living Deceased

Brother's / sister's health _____ Living Deceased

Brother's / sister's health _____ Living Deceased

Health History

Height _____ Weight _____

Please list all previous surgeries and dates _____

_____

Please list all current medications and supplements (specify amount, if possible) _____

_____

_____

_____

Please list all auto accidents and dates _____

_____

Diet

Do you have any diet restrictions? ☐ Yes ☐ No If so, describe _____

Do you have any food allergies? ☐ Yes ☐ No If so, describe _____

Do you have any food sensitivities? ☐ Yes ☐ No If so, describe _____

Do you have any food cravings? ☐ Yes ☐ No If so, describe _____

Do you eat regular meals? ☐ Yes ☐ No If not, describe _____

Lifestyle

Do you sleep well? ☐ Yes ☐ No Do you wake rested? ☐ Yes ☐ No

Do you dream? ☐ Yes ☐ No Hours/night _____

Energy high point of the day _____ Energy low point of the day _____

☐ Tobacco Type & Frequency _____

☐ Alcohol Type & Frequency _____

☐ Caffeine Type & Frequency _____

☐ Drugs Type & Frequency _____

☐ Exercise Type & Frequency _____

☐ Stress Type & Frequency _____

Occupational Hazards (i.e., exposure to pollution or chemicals) ☐ Yes ☐ No

Systems Review

Please circle all of the symptoms that you have experienced **during the past 6 months**:

Head, Eyes, Ears, Nose, Throat		
Glasses	Ear ringing	Teeth removed
Night blindness	Hearing loss	Numerous cavities
Eye strain	Earaches	Teeth grinding
Eye pain	Fullness in ears	TMJ
Red eyes	Headaches	Gum problems
Itchy eyes	Migraines	Sore lips
Spots in eyes	Concussions	Mouth sores
Spots in vision	Throat drainage	Sore tongue
Blurred vision	Sore throat	Excessive saliva
Glaucoma	Dry throat	Dry mouth
Cataracts	Excessive thirst	Facial pain
Nosebleeds	Lack of thirst	Facial numbness
Heaviness of head	Lump in throat	Sinus congestion
Swollen glands	Enlarged thyroid	Sinus drainage
Respiratory		
Difficulty breathing	Tight chest	Pleurisy
Shortness of breath	Asthma	Phlegm / congestion
Acute cough	Allergies	Rattling breath sounds
Chronic cough	Wheezing	Cannot sleep lying down
Coughing blood	Pneumonia	
Cardiovascular		
High blood pressure	Slow heart rate	Edema (swelling)
Low blood pressure	Rapid heart rate	Blood clots
Chest pain	Irregular heart rate	Heart disease
Palpitations	Pacemaker	Heart attack

Gastrointestinal		
Nausea	Hiccups / belching	Diarrhea
Vomiting	Bad breath	Constipation
Acid reflux / heart burn	Prefer cold drinks	Hemorrhoids
Poor appetite	Prefer hot drinks	Rectal pain / itching
Heavy appetite	Stomach pain	Blood in stool
Bloating	Indigestion	Intestinal pain
Genito-urinary		
Pain with urination	Waking to urinate	Impotence
Frequent urination	Bed wetting	Premature ejaculation
Urgent urination	Dribbling	Nocturnal emissions
Incomplete urination	Frequent UTIs	Increased libido
Blood in urine	Kidney stones	Decreased libido
Musculoskeletal		
Muscle weakness	Joint pain	Acute pain
Muscle cramps	Joint instability	Chronic pain
Muscle spasms	Limited range of motion	General aches
Muscle atrophy	Arthritis	Injuries or falls
Body heaviness	Numbness	Scoliosis
Neurological		
Fainting / syncope	Dizziness	Vertigo
Drowsiness	Loss of balance	Paralysis
Tremor	Seizures	Numbness
Stroke / CVA / TIA	Convulsions	
Neurophysical		
Irritable	Anxious / worries easily	Loss of motivation
Easily stressed	Panic attacks	Unresolved grief
Easily frustrated	Poor memory	Frightens easily
Depression	Confusion	Abuse survivor
Skin and Hair		
Rashes	Psoriasis	Hair loss
Hives	Acne	Hair changes
Ulcerations	Itching	Hair breaking
Eczema	Dandruff	Thin / slow growing nails
Fungal infection	Premature graying	Skin changes
Vitality and Immune System		
Frequent colds	Lethargic	Slow wound healing
Frequent flus	Low energy	Bruise easily
Cold hands and feet	Mental cloudiness	Tender / achy all over
Chills	Weight loss	Night sweating
Fever	Weight gain	Spontaneous sweating

Gynecology ☐ N/A		
Pregnant Could be pregnant Trying to get pregnant Pregnancies # _____ Miscarriages # _____ Premature births # _____ Date of last PAP? _____ Date of last mammogram? _____	Age of menarche (first menses) _____ Age of menopause _____ Pain before menstruation Pain during menstruation Pain after menstruation Heavy bleeding Blood clots	PMS Breast tenderness Breast itching Spotting between cycles Vaginal discharge Vaginal odor Vaginal pain Vaginal itching Vaginal dryness
Current Menses ☐ N/A		
Length of cycle _____days	Duration of flow ____ days	Irregular cycles

Diagnoses Please list any diagnoses you have been given by your medical doctor.
1.
2.
3.
4.
5.

Other: _____

Of these symptoms, which is your major complaint? _____

Please fill out a Current Health Complaint section for EACH of the symptoms circled above that you experience currently. Please be as thorough as possible so we can best assess how to help you!

Please read and sign below:

The information that I have provided on these case history forms is true and accurate to the best of my knowledge. I give Dr. Janine Pulley permission to render care to me today. This initial visit includes a health history / consultation, chiropractic examination, and any initial care that is determined to be clinically necessary and mutually agreed upon.

_____ _____

Patient Signature Date

Current Health Complaint

Complaint _____

Have you had it before? ☐ Yes ☐ No The onset was ☐ Sudden ☐ Gradual

When did it begin? _____

What caused it? _____

Where is it located? _____

What is its frequency? ☐ 0-25% of the time ☐ 25-50% ☐ 50-75% ☐ 75-100%

How would you describe it? ☐ Dull ☐ Achy ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Numb

☐ Tingling ☐ Burning ☐ Other _____

How would you rate its intensity on a scale of 0 to 10? _____

(With 0 = no problem and 10 = so bad that you had to be carried into the office)

What makes it better? _____

What makes it worse? _____

Does it interfere with daily activities?

☐ Standing ☐ Sitting ☐ Walking ☐ Bending ☐ Recreation ☐ Work ☐ Sleeping

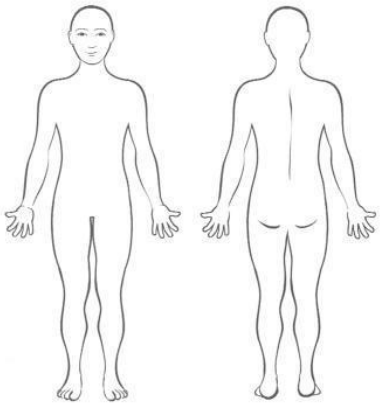
☐ Sexuality ☐ Social Life ☐ Relationships ☐ Emotional ☐ Other _____

Have you tried any therapies? ☐ Yes ☐ No If so, have they helped? ☐ Yes ☐ No

If so, what have you tried? ☐ Chiropractic ☐ Acupuncture ☐ PT ☐ Medication

☐ Surgery ☐ Other _____

Please indicate where your complaint is located on the diagram below:



^ ^ ^ ^ ^ ^	Aching
= = = = =	Numbness
O O O O O	Pins & Needles
X X X X X	Burning
/ / / / / / /	Stabbing
. . . . .	Other