PulleyChiropractic & ACUPUNCTURE

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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) _____ (C) _____

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

Please sign me up for automatic appointment reminders via text!

If you wish to opt-out, please initial here: _____

Any additional contact instructions _____

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

Gender: ☐ M ☐ F Sex at Birth: ☐ 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 _____

Previous nutritional counseling? ☐ Yes ☐ No Nutritionist'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

☐ Gluten-free ☐ Vegetarian ☐ Vegan ☐ Paleo / Primal / Keto ☐ Other: _____

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 _____

Are you interested in a complimentary nutritional systems survey? ☐ Yes ☐ No

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: ☐ Cigarettes ____ pack/day ☐ Cigars ☐ Oral Tobacco

☐ Alcohol: # ____ drinks // day /week / month

☐ Beer ☐ Wine ☐ Hard Liquor ☐ Mixed Drinks

☐ Caffeine: ☐ Tea ☐ Coffee # ____ cups // day /week / month

☐ Drugs: Type & Frequency _____

☐ Exercise: ☐ Cardio ☐ Strength Training ☐ Yoga ☐ Sports ☐ Cross-Fit

☐ Running ☐ Other Frequency: #_____ / week

☐ Stress: ☐ Work ☐ Family ☐ Medical ☐ Financial ☐ Other _____

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	Numerous cavities
Night blindness	Hearing loss	Teeth grinding
Eye strain	Earaches	TMJ
Eye pain	Fullness in ears	Gum problems
Red eyes	Headaches / migraines	Sore lips
Itchy eyes	Concussions	Mouth sores
Dry eyes	Throat drainage	Sore tongue
Spots in vision	Sore or dry throat	Excessive saliva
Blurred vision	Excessive thirst	Dry mouth
Glaucoma	Lack of thirst	Facial pain
Cataracts	Lump in throat	Facial numbness
Nosebleeds	Enlarged thyroid	Sinus congestion
Heaviness of head	Swollen glands	Sinus drainage
Respiratory		
Difficulty breathing	Tight chest	Pleurisy
Shortness of breath	Asthma	Phlegm / congestion
Acute cough	Seasonal allergies	Rattling breath sounds
Chronic cough	Environmental allergies	Cannot sleep lying down
Coughing blood	Wheezing	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	Light-headed
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		
Overall I feel hot	Lethargic / low energy	Slow wound healing
Overall I feel cold	Mental cloudiness	Bruise easily
Cold hands and feet	Weight loss	Tender / achy all over
Chills	Weight gain	Night sweating
Fever	Frequently sick	Spontaneous sweating

Gynecology ☐ N/A		
Pregnant	Age of menarche (first	PMS
Could be pregnant	menses) _____	Breast tenderness
Trying to get pregnant	Age of menopause _____	Breast itching
Pregnancies # _____		Spotting between cycles
Miscarriages # _____	Pain before menstruation	Vaginal discharge
Premature births # _____	Pain during menstruation	Vaginal odor
Date of last PAP? _____	Pain after menstruation	Vaginal pain
Date of last mammogram?	Heavy bleeding	Vaginal itching
_____	Blood clots	Vaginal dryness
Current Menses ☐ N/A		
Length of cycle _____days	Duration of flow ____ days	Irregular cycles
(How many days between?)	(How long does it last?)	
Are you on birth control? ☐ Yes ☐ No What kind:		

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

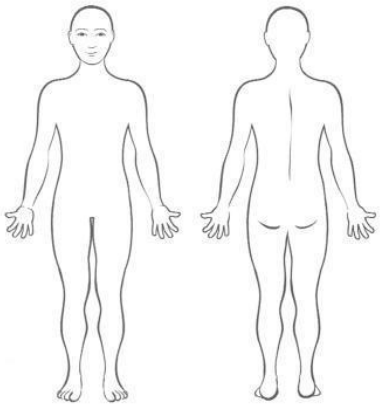
☐ Sexuality ☐ Social Life ☐ Relationships ☐ Emotional ☐ Other _____

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

If you have another complaint, please fill out another Current Health Complaint form.

Diagnoses

Please list any diagnoses you have been given by your medical doctor.

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

Other: _____

Please fill out a Current Health Complaint section for EACH of the complaints you would like to address.

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. This initial visit includes a health history / consultation, examination, and any initial care that is determined to be clinically necessary and mutually agreed upon. I give Dr. Janine Pulley permission to render care to me today.

_____ _____

Patient Signature Date