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 **CHECK** 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

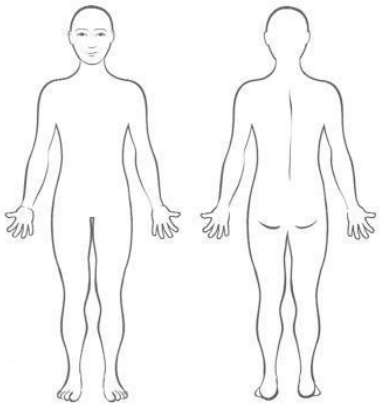
☐ Sexuality ☐ Social Life ☐ Relationships ☐ Emotional ☐ Other _____

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