Natural Living Chiropractic and Acupuncture
1292 Main Street, Unit 4
Windsor, CO 80550
(970)460-9258

Client Intake Form - Acupuncture

Appointment Date: _____ Email Address: _____

Name: _____
First Middle Last

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: ____/_____/_____ Gender: M F Height: _____ Weight: _____
MM DD YY

Marital Status: S M D W Number of Children: _____ Occupation: _____

Primary Care Physician: _____
Physician's Phone #: _____ Last Physical Examination Date: _____

Emergency Contact: _____
Name Relation Phone #

Referred By: _____

Personal Medical History (Surgeries, Hospitalizations, Illness, Diseases, Accidents and dates):

Contagious Diseases: _____ None _____ HPV _____ Herpes _____ MRSA
_____ AIDS _____ Hepatitis (A, B, C, D) _____ STDs _____ Other _____

Allergies:

Medications / Herbs / Vitamins / Supplements you are currently taking (and in recent past):

Family Medical History (parents, grandparents, siblings, children):

____ Alcoholism	____ Allergies	____ Arthritis	____ Asthma	___ TB
____ Diabetes	____ Drug Abuse	____ Epilepsy	____ Eye Disease	
____ Heart Disease	____ High/Low BP	____ Kidney Disease	____ Liver Disease	
____ Mental Health	____ Sinus Problems	____ Spinal Problems	____ Stroke	

Age Parents Died: ____ Mother ____ Father

Present Illness:
What is your chief complaint?

When & how did this condition begin?

What treatment have you received for this condition?

Effectiveness of treatment received?

What makes it better?
What makes it worse?

What are your goals/expectations for care (circle which apply)

1. Relief and prevention of problem (list specific problem)
2. Healthier Spine and nervous system
3. Optimal health on all levels
4. Other: (list specific goal you might have here)

Lifestyle Habits:

____ Black Tea ____ Coffee ____ Chewing Tobacco ____ Alcohol ____ Soft Drinks
____ Cigarettes ____ Sugar ____ Recreational Drugs ____ Salt ____ Other

Exercise: ____ Never ____ Occasional ____ Moderate ____ Heavy
Type of Exercise: _____

Emotions:

____ Happy (excess / deficient) ____ Anxious / Restless ____ Controlling
____ Worrier ____ Over Thinker ____ Stubborn
____ Sadness / Grief ____ Cries Easily ____ Aloof
____ Fear ____ Reckless ____ Poor Willpower
____ Angry / Irritable ____ Depression ____ Other _____
____ Even ____ Decision Making Difficulty

Energy:

____ Normal ____ Low after eating ____ Low in afternoon
____ Low ____ Excess ____ More energy at night
____ Variable ____ Other _____

Weight:

____ Normal ____ Underweight ____ Overweight
____ Recent Gain (how much? ____) ____ Recent Loss (how much? ____)

Appetite:

____ Variable ____ Poor ____ Good ____ Excessive
____ Hungers Rapidly ____ Loss of Taste ____ Other _____

Diet (describe a typical meal):
Breakfast:
Lunch:
Dinner:
Cravings: _____

Do you eat 3 meals a day? _____ Do you eat at regular hours? _____ Do you eat late at night? _____

Digestion:

____ Normal ____ Heartburn ____ Belching / Burping ____ Gas
____ Bitter taste ____ Nausea / Vomit ____ Nervous stomach ____ Bloating
____ Bad breath ____ Gallstones ____ Stomach noises ____ Hiccups
____ Full feeling or distention ____ Abdominal pain / cramps ____ Indigestion
____ Difficulty digesting fatty / oily foods ____ Food doesn't descend
____ Other _____

Bowels:

____ Normal ____ Alternating constipation & diarrhea / loose stool
____ Loose stool ____ Black stool ____ Burning anus
____ Diarrhea ____ Blood in stool ____ Stool with bad smell ____ Intestinal worms
____ Constipation ____ Hemorrhoids ____ Colon problems ____ Undigested food in stool
____ Hard stool ____ Anus itch ____ Laxative use
____ Pain / cramps ____ Small stool amount ____ Mucous in stool ____ Other _____

Urination: (4-6x per day is normal)

____ Dribbling after urination
____ Normal ____ Burning ____ Bladder infections ____ Urgency
____ Frequent ____ Blood ____ Incontinence ____ Cloudy
____ Profuse ____ Pus/infections ____ Strong smell ____ Painful
____ Scanty ____ Kidney stones ____ Night time ____ Abnormal Color

Body Temperature:

____ Normal ____ Warm natured ____ Feel warmer in late afternoon & night
____ Cold natured ____ Warm palms
____ Cold hands and feet ____ Warm soles ____ Alternate chills & fever
____ Cold lower body ____ Warm upper body ____ Flushed face
____ Other _____

Perspiration:

____ Normal ____ Head ____ Chest ____ Bad smell
____ Profuse ____ Palms ____ Without exertion ____ Night sweats
____ Small amount ____ Feet ____ Oily ____ Hot flashes
____ Other _____

Thirst:

____ Normal ____ Thirsty but do not drink ____ Prefer cold drink ____ Less than normal
____ Excessive ____ Increased thirst at night ____ Prefer hot drink ____ Other _____

Sleep:

____ Normal ____ Vivid dreams ____ Awake tired in morning
____ Difficulty falling asleep ____ Nightmares
____ Difficulty going back to sleep ____ Restless ____ Sleep too much
____ Wakes easily ____ Other _____

Headaches / Dizziness:

____ Heavy headed feeling
____ Headaches ____ Dizziness ____ Fainting ____ Poor balance
____ Migraines ____ Vertigo ____ Motion sickness ____ Poor memory
____ Dizziness with changes in position ____ Other _____

Skin:

____ Normal
____ Oily
____ Dry
____ Itching
____ Rashes
____ Eczema
____ Ulcers
____ Hives
____ Acne
____ Other _____
____ Boils
____ Moles
____ Warts
____ Clammy
____ Body odor
____ Bruise easily
____ Slow to heal
____ Yellow skin

Hair:

____ Normal
____ Prematurely grey
____ Oily
____ Dry / brittle
____ Dandruff
____ Other _____
____ Falling out

Nails:

____ Normal
____ Brittle / break easily
____ Ridged / lines
____ Spots
____ Pale
____ Purple
____ Grow slowly
____ Grow rapidly
____ Soft
____ Other _____

Eyes:

____ Normal
____ Need glasses/contacts
____ Spots / lines in vision
____ Poor night vision
____ Light sensitivity
____ Color blindness
____ Pale under eyelids
____ Eyelids swollen
____ Inflammation
____ Yellow sclera
____ Failing vision
____ Sty history
____ Blurry vision
____ Other _____
____ Cataracts
____ Glaucoma
____ Tearing
____ Twitching
____ Blinking
____ Macular degeneration
____ Red
____ Dry
____ Itching
____ Pain
____ Strain

Ears:

____ Normal
____ Poor hearing
____ Ear aches / pain
____ Other _____
____ Ringing (high pitched)
____ Ringing (low pitched)
____ Whooshing sound
____ Discharges
____ Infections
____ Itching

Nose:

____ Normal
____ Congestion
____ Mucous
____ Sinusitis
____ Allergies
____ Rhinitis
____ Overly dry
____ Bleeding
____ Sneezing
____ Post nasal drip
____ Structural problems
____ Loss of smell sensitivity
____ Environmental
____ Nasal sores
____ Nasal polyps
____ Other _____

Mouth & Throat:

____ Normal
____ Frequent sore throats
____ Tonsillitis
____ Swollen glands
____ Thyroid problems
____ Dry
____ Difficulty swallowing
____ Lump in throat feeling
____ Gum problems
____ Mouth / tongue sores
____ TMJ
____ Other _____
____ Grind teeth
____ Teeth problems
____ Dry/cracked lip
____ Drooling
____ Hoarseness

Respiratory:

____ Normal
____ Shortness of breath
____ Asthma
____ Bronchitis
____ Lung cancer
____ Emphysema / COPD
____ On oxygen
____ Difficult inhalation
____ Difficult exhalation
____ Difficult breathing when lying down
____ Chest pain
____ Tightness in chest
____ Other _____
____ Excess coughing
____ Dry cough
____ Cough with phlegm
____ Cough with blood
____ Frequent sighing
____ Frequent colds

Cardiovascular / Circulation:

____ Normal
____ Palpitations
____ High cholesterol

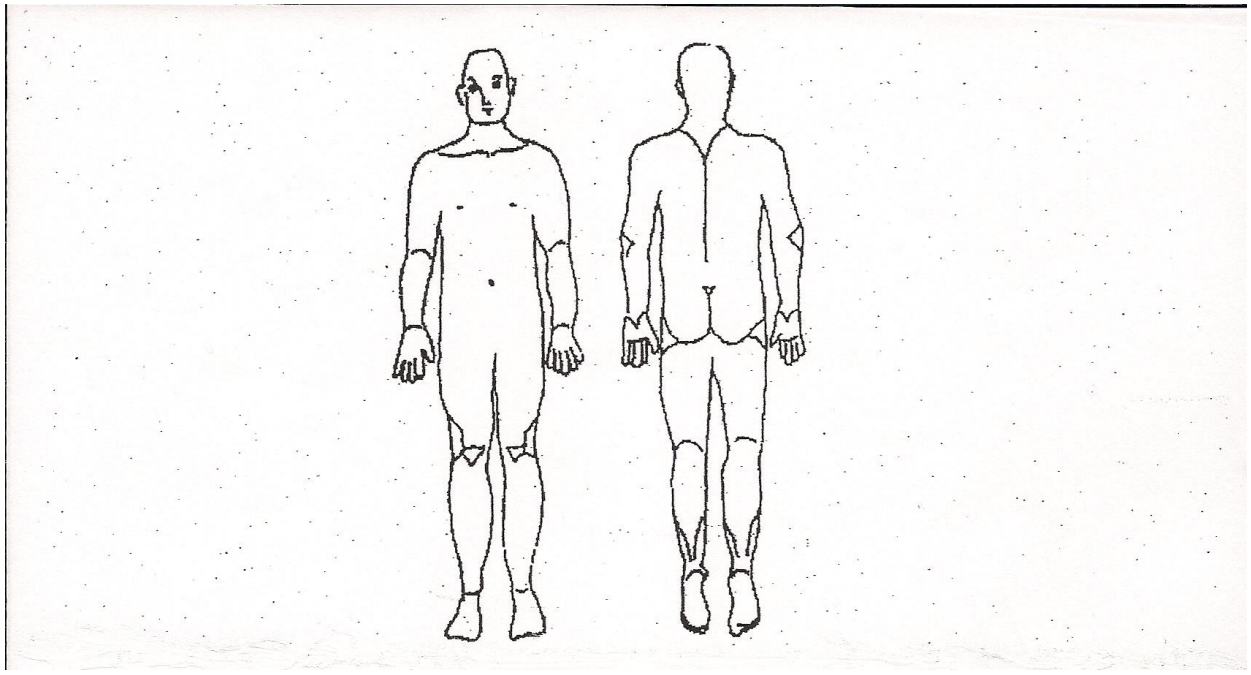
____ Murmur
____ Anemia
____ Low blood pressure
____ High blood pressure
____ Slow heart beat
____ Fast heart beat
____ Irregular heart beat
____ Diagnosed heart problems

____ Bleed easily
____ Bleeding disorder
____ Blood clots
____ Bruise easily
____ Varicose veins
____ Broken blood vessels
____ Purple hands/feet
____ Other _____

____ Low cholesterol
____ Chest pain
____ Numb / tingling extremities
____ Swelling (ankle, hands, face)

Pain:

Please mark with an X where you feel pain and discomfort and describe
(dull, ache, sharp/stabbing, burning, distending, throbbing, spasms, twitching etc.)



What makes the pain worse?

What makes the pain better?

Any other problems you would like to discuss?

For Males Only:

____ Reduced sex drive
____ Premature ejaculation
____ Seminal emissions
____ Pain / burning with urination
____ Other
____ Impotence
____ Sperm problems
____ Prostate problems
____ Dribbling after urination
____ Genital pain
____ Hernia
____ Discharges

For Females Only:

Are you pregnant? ____ Yes ____ No
If yes, approximate date of conception?
What method of birth control do you currently use?
What method of birth control have you used in the past?

Do you have regular PAP tests?	____ Yes	____ No
Do you complete regular breast exams?	____ Yes	____ No
Do you have breast implants?	____ Yes	____ No
Do you have excess facial or body hair?	____ Yes	____ No
Do you have a reduced sex drive?	____ Yes	____ No

Menstrual Cycle:

Age started? _____ Days of flow? _____ Age stopped? _____
How many days from the beginning of your period to the beginning of the next one? _____

Check all that apply

____ Irregular
____ No menses
____ Heavy flow
____ Scanty flow
____ Dark flow color (dark red, purple)
____ Light flow color (light red, brownish)
____ Water retention
____ Abdominal bloating
____ Painful / tender breasts
____ Breast lumps
____ Mood swings / changes
____ Spotting between periods
____ Lump in throat feeling
____ Constipation &/or diarrhea
____ Chest Tightness
____ Pain / cramps
____ Clotting
____ Sighing
____ Backache
____ Skin eruptions
____ Other _____

Discharges:

____ Thick
____ Yellow
____ Blood
____ White
____ Clear
____ Other _____
____ Bad odor
____ Yeast infections
____ Itching
____ None

Pregnancies:

Total number? _____ Number of miscarriages? _____
Number of children? _____ Number or abortions? _____
Any pregnancy or childbirth complications? (explain)

Menopause:

____ Hot flashes
____ Night sweats
____ Poor sleep
____ Irritable
____ Mental restlessness
____ Other _____
____ N/A
____ Vaginal dryness
____ Memory problems
____ Tinnitus
____ Backache
____ Palpitations
____ Frequent urination
____ Dizziness
____ Fatigue
____ Anxiety
____ Feel cold
____ Dry mouth
____ Cold feet

Any other gynecological concerns?

Payment in full is expected at the time of service.

Please Read, Mark the Boxes and Sign

☐ I acknowledge that Natural Living Chiropractic & Acupuncture has informed me that Dr. Jacquelyn Schorling, Dr. Sheldon Quigley, Ellen Williams L. Ac and Megan Spear LMT, are not in network with any insurance companies. Therefore, we are unable to guarantee that claims for any services rendered by Natural Living Chiropractic & Acupuncture will be covered under self-made claims.

☐ Natural Living Chiropractic & Acupuncture's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review at the front desk.

☐ I consent to receive communication from Natural Living Chiropractic & Acupuncture via email, postal mail, text and telephone messaging in connection with my care. If I should withdraw my consent, I will notify the office in writing.

☐ I certify that I am not now and will not be under the influence of alcohol, marijuana, or illegal substances during my office visits.

☐ I acknowledge that in order to be considered an "active patient" I need to be seen no less than every 14 months. I understand that if I am unable to come in within that 14-month timeframe that I will need to re-establish care in the office as a new patient.

☐ I acknowledge that an active card on file is required to reserve appointment times. You can update this card at any time, and if you prefer to pay with a different method, just let us know at check-in. We prioritize your privacy, and our platform is fully encrypted to protect your information

☐ I acknowledge that if I arrive late for a massage appointment, the time lost will be deducted from the total duration of the session

☐ I acknowledge that I understand the following cancellation policy:

We understand there are times when a patient must miss an appointment. However, when you do not call to cancel, you prevent another person from utilizing that time. All cancellations require 24-hour notice. **Failure to give sufficient notice and no call/no show will result in a charge of full price of the scheduled missed service**.

The information I have provided on this case history form is true and accurate to the best of my knowledge.

I give Dr. Jacquelyn Schorling, Dr. Sheldon Quigley, Ellen Williams L. Ac. and Megan Spear LMT permission to render care to me today.

Name: (Printed) _____Date: _____

Signature: _____

Signature of Parent (for minor): _____ Date: _____

Thank you for choosing Natural Living Chiropractic & Acupuncture.
We look forward to helping you and your family.