Whole Body Health, P.A. / Acupuncture Wellness Center
2525 Wallingwood Drive, Suite 1500, Austin, TX 78746

Patient Information

Patient Name (Last): _____ (First): _____ (Middle): _____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Home Phone (____) _____

Work Phone: (____) _____ Cell Phone: (____) _____

Fax: (____) _____ Date of Birth: ___ /___ /_____ Age: _____ Gender: M __ F __

Social Security#: _____-_____-_____ Driver's License #-_____ Marital Status: S __ M __ D __ W __

Number of Children _____ Occupation _____ Work Status: __ Full time __ Part-time __ Retired

Work Activity: __ Heavy Labor __ Light Labor __ Mostly Sitting __ Mostly Standing __ Walking / Moving __ Driving

Do you like your work? __Y __N

Name of Spouse _____ Occupation _____

Is this condition due to injury or sickness arising out of auto or other accident? _____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

Name: _____ Home Phone (____) _____ Cell Phone: (____) _____

Address: _____

How did you hear about our clinic? _____

Name of your primary doctor: _____ Phone (____) _____

Address: _____ City: _____ State: _____ Zip: _____

My office visit today is for (circle appropriate answer) acupuncture chiropractic kinesiology massage EFT combination

I, the undersigned, hereby give my consent to Dr. Ulery, D.C. of Whole Body Health, P.A./ Moira J. McCarthy of Acupuncture Wellness Center to contact my primary care doctor with information concerning my case. __ Y __ N _____
Signature

Complaint / Problem

What is your current health problem, symptom, or complaint? _____

When did you first seek treatment for this problem? _____/_____ Other doctor seen for this condition _____

When was the first time you noticed this problem? Is this a recurrence? _____

How did it originally occur? _____ Has it become worse recently? Y / N __ Same __Better __ Gradually Worse

How frequent is the condition? __ Constant __ Daily __ intermittent __ Night only How long does it last? __ All day __ Hrs __Minutes

Are there any other conditions or symptoms that may be related to your major symptom? __ Y __ N

If yes, describe _____

Is this condition interfering with your: __ Work __ Sleep __ Daily routine __ Other _____

How long has it been since you really felt good? __ Days __ Weeks __ Months __ Years __ > 10 years

Describe the pain: __ Sharp __ Dull __ Numbness __ Tingling __ Aching __ Burning __ Stabbing __ Other _____

What makes the problem worse? __ Standing __ Sitting __ Lying __ Bending __ Lifting __ Twisting __ Other _____

Is there anything that you can do to relieve the problem? __ Y __ N If yes, describe _____

If no, what have you tried to do that has not helped? _____

What do you believe is wrong with you? _____

What are your health goals? pain relief prevention maintenance correction

List surgical procedures and give dates: _____

Have you ever been in an auto accident? __ Past few wks __Past year __ Past 5 years __ Over 5 years __ Never

Describe _____

Please rate the pain, related to your current condition, using the following scales: (0= no pain, 10 = worst pain)

	0	1	2	3	4	5	6	7	8	9	10
Current pain intensity	__	__	__	__	__	__	__	__	__	__	__
Average pain intensity	__	__	__	__	__	__	__	__	__	__	__
Worst pain intensity	__	__	__	__	__	__	__	__	__	__	__

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Please check the appropriate box for any of the following symptoms which you have experienced in the **last year**. Be sure to include the symptoms that you have "learned to live with."
Enter the number of symptom occurrence **1-2-3** after each symptom that best describes your condition:
1 = mild - this symptom occurs once or twice a month.
2 = moderate - this symptom occurs one to three times a week
3 = severe - this symptom occurs daily.
Blank = this symptom does not apply to me.

Cardiovascular
___ Arteriosclerosis
___ ***Chest Pains***
___ High/Low Blood Pressure
___ ***Irregular Heartbeat***
___ Pain Over Heart
___ Poor Circulation
___ Rapid/Slow Heart Beat
___ Swelling of Ankles
___ Varicose Veins

Emotions
___ ***Aggressiveness***
___ ***Anxiety / Fear***
___ ***Depression***
___ ***Irritability / Anger***
___ ***Mood Swings***
___ ***Nervousness***

Energy / Activity
___ ***Apathy***
___ ***Fatigue***
___ ***Hyperactivity***
___ ***Lethargy***
___ ***Restlessness***
___ ***Sluggishness***

Eyes, Ears, Nose & Throat
___ ***Blurred Vision***
___ ***Canker Sores***
___ Colds
___ ***Dark Circles Under Eyes***
___ Deafness
___ Dental Decay
___ ***Ear Ache***
___ ***Ear Discharge***
___ ***Ear Infections***
___ ***Ear Noises / Ringing***
___ Enlarged Glands / Thyroid
___ Eye Pain
___ Failing Vision
___ Far / Nearsightedness
___ ***Gagging***
___ Gum Trouble
___ Hay Fever
___ ***Hearing Loss***
___ ***Itchy Ears / Eyes***
___ ***Often Clear Throat***
___ ***Sinus Problems / Infections***
___ ***Sneezing Attacks***
___ ***Sore Throat***
___ ***Sticky Eyelids***
___ ***Stuffy Nose***
___ ***Swollen Eyelids***
___ ***Swollen Tongue/Lips/Gums***
___ ***Watery Eyes***

Gastrointestinal
___ ***Belching***
___ ***Bloated Feeling***
___ Colitis
___ Colon Trouble
___ ***Constipation***
___ ***Diarrhea***
___ Difficult Digestion
___ Gallbladder Trouble
___ Hemorrhoids
___ Indigestion / Heartburn
___ Intestinal Parasites
___ Liver Trouble
___ ***Nausea / Vomiting***
___ ***Pain Over Stomach***
___ ***Passing Gas***
___ Poor Appetite
___ Vomiting Blood

Genitourinary
___ Bed Wetting
___ Blood in Urine
___ Frequent Urination
___ Kidney Infection or Stones
___ Painful Urination
___ Prostate Trouble
___ ***Urgent Urination***

Head
___ ***Dizziness / Lightheaded***
___ ***Headache***
___ ***Insomnia / Loss of Sleep***

Mind
___ **Confusion**
___ **Learning Disabilities**
___ **Poor Concentration**
___ **Poor Memory**
___ **Stuttering / Stammering**

Muscle & Joints
___ ***Aches in Muscles***
___ ***Arthritis / Pain in Joints***
___ Bursitis
___ ***Feeling of Weakness***
___ Foot Trouble
___ Hernia
___ ***Limited Movement***
___ Low Back Pain
___ Neck Pain / Stiff
___ Pain between Shoulders
___ Pain or Numbness in:
___ Shoulders
___ Arms/Elbows/Hands
___ Hips/Legs/Knees/Feet
___ Painful Tailbone
___ Poor Posture
___ Sciatica
___ Spinal Curvature
___ ***Stiffness***
___ Swollen Joints

Respiratory
___ ***Asthma / Bronchitis***
___ ***Chest Congestion / Pain***
___ Chronic Cough
___ ***Difficulty Breathing***
___ ***Shortness of Breath***
___ Spitting Up Blood/Phlegm
___ ***Wheezing***

Skin
___ ***Acne***
___ Bruise Easily
___ ***Dermatitis***
___ Dryness
___ ***Eczema***
___ ***Excessive Sweating***
___ ***Hair Loss***
___ ***Hives / Rashes***
___ ***Itching***

Weight
___ ***Binge Eating***
___ ***Compulsive Eating***
___ ***Cravings***
___ ***Excessive Weight***
___ ***Underweight***
___ ***Water Retention***

Other
___ ***Allergies***
___ ***Anaphylactic Reactions***
___ Convulsions
___ Fainting
___ Fever
___ ***Frequent Illness***
___ ***Genital Itch***
___ ***Loss of Weight***
___ Neuralgia / Nerve Pain
___ Numbness
___ Sweats

For Women Only
___ Fibrocystic / Congested Breasts
___ Cramps &/or Back Pain
___ Excessive Menstrual Flow
___ ***Hot Flashes / Flushing***
___ Irregular Cycle
___ Menopausal Symptoms
___ Night Sweats
___ Painful Menstruation
___ Vaginal Discharge
___ Yeast Infections
___ Pregnant? Y N

*****If you have one or more of these symptoms (bold & italics), there is a 95% probability you'll benefit from a food sensitivity test.***

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Identify any conditions that **you or any of your family members** have now or have had in the past:
G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self

__Alcoholism	__Alzheimer's	__Anemia	__Anxiety	__Cancer	__Cataracts
__Chicken Pox	__Chorea	__Cold sores	__Diabetes	__Emphysema	__Epilepsy
__Fever blisters	__Goiter	__Detached retina	__Gout	__Heart disease	__HIV / AIDS
__Malaria	__Measles	__Miscarriages	__Mumps	__Pleurisy	__Pneumonia
__Polio	__Rheumatic fever	__Scoliosis	__Stroke	__Tumors	__Ulcers
__Venereal disease		__Deep vein thrombosis		__Macular Degeneration	

HAVE YOU EVER: **DESCRIBE BREIFLY**
Been knocked unconscious? __ Y __ N _____
Been treated for a spine or nerve disorder? __ Y __ N _____
Had a broken bone? __ Y __ N _____
DO YOU:
Think that you may need vitamins or minerals? __ Y __ N __ Unsure _____
Have an allergy to any drug? __ Y __ N _____

Please answer the following questions:

Does your whole arm or leg feel painful? _____ __ Y __ N
Does your whole arm or leg feel numb? _____ __ Y __ N
Have you had any pain-free times in the past year? _____ __ Y __ N
Have you had any intolerance or reactions to treatments? _____ __ Y __ N
Have you ever been to the emergency room for back pain? _____ __ Y __ N
Have you felt irritable / keyed up or on edge? _____ __ Y __ N
Have you had hormone problems? _____ __ Y __ N
Have you had recurrent infections? _____ __ Y __ N
Have you had blood sugar imbalances? Hypo/ Hyperglycemia? _____ __ Y __ N
Have you had decreased libido / sex drive? _____ __ Y __ N
Have you had a difficult time relaxing? _____ __ Y __ N
Have you been sleeping poorly? _____ __ Y __ N
Have you had difficulty falling asleep? _____ __ Y __ N
Have you been waking up early? _____ __ Y __ N
Do you tend to feel worse in the morning? _____ __ Y __ N
Do you get dizzy when rising from sitting or lying? _____ __ Y __ N
Have you been worried about your health? _____ __ Y __ N

DATE OF LAST:	**Less than 6 months**	**6-18 months**	**Over 18 months**	**Never**
Spinal examination				
Physical examination				
Blood test				
Urine test				

HABITS	**Heavy**	**Moderate**	**Light**	**None**
Alcohol				
Appetite				
Coffee				
Exercise				
Recreational Drugs				
Tobacco				
Sleep				
Soda / Diet Soda				
Water				

Have you been treated for any health condition by a physician in the last year? __ Y __ N If so, please identify:

Condition: _____ Doctor: _____ Outcome: Resolved / Ongoing / Other

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Medications, Supplements, Surgeries & Hospitalizations

1. Please list ALL **medications** taken within the last 30 days, how often and why you are taking them.
2. Please list ALL **supplements** taken within the last 30 days, how often and why you are taking them.

Meds/Supplement	Started Taking	Why do you take this?

Please list ALL surgeries performed on you, when it was done and how you have felt since having the surgery.

Surgical Procedure?	What approx. year?	How you have felt since the procedure?

Please list any hospitalizations you have had (other than the above listed surgeries).

Why were you there?	When?	What was the outcome?

Please list any additional information that you would like your practitioner to know regarding your health. If necessary please use a separate sheet of paper and label it with your name and date of birth. Thank You!