Acupuncture & Wellness Services Intake Questionnaire

EMERGENCY RESPONDERS HEALTH CENTER

Today's Date: _____/_____/_____ ☐ **Female** ☐ **Male**

Legal Name: First: _____ Middle Initial: _____ Last: _____

Preferred First Name: _____ **Birth Date:** _____/_____/_____ **Age:** _____

Contact Info: Phone: ( ) _____-_____ ☐ Cell ☐ Landline Email Address: _____

If you wish to receive appointment reminders by text, please include your cell phone number.

☐ I am an established patient of Emergency Responders Health Center. Please use the address on file.

☐ I am not an established patient of Emergency Responders Health Center. Please use the following address:

Street Address: _____

City: _____ State: _____ Zip: _____

Profession: ☐ Fire ☐ Law Enforcement ☐ EMS ☐ Emergency Dispatch

☐ Other: _____
(Note Profession)

☐ Military Service: _____
(Note active duty, reserve, or veteran, and branch of service.)

***IF* First Responder:** ☐ Active-Duty Responder ☐ Chief/Deputy Chief ☐ Administrator ☐ Retired

Current Employer: _____ **Since:** _____/_____
MM YY

Primary Care Physician and Physical Therapist:

☐ I currently see the following ERHC provider(s):

○ Rob Hilvers, MD ○ John Wick, MD ○ Jenna Rovig, NP-C ○ Chelsea Wallace, NP-C

○ Mike Owens, PT ○ Jami Whiles, PT ○ Other_____

☐ I see the following third-party medical provider:

Physician Name: _____

Practice Phone: ( ) _____-_____

Email Address: _____

How did you hear about ERHC's in-house acupuncture clinic?

☐ Marketing Flyer or Signals e-newsletter ☐ Word-of-Mouth (i.e., another patient)

☐ ERHC 360 Directory Listing ☐ Referral From: _____

Reason for Seeking Care _____

Please describe the <u>primary concern</u> for which you are seeking relief: *This form contains a pain index on page 7.*

Indicate the severity of this condition, when symptoms are <u>the worst</u>. (How bad does this condition get?)
Circle the most appropriate number, corresponding with your level of discomfort.

0	1	2	3	4	5	6	7	8	9	10

No Discomfort *Most Discomfort*

Indicate the severity of this condition, when symptoms are <u>the best</u>. (What is the least bad this condition gets?)
Circle the most appropriate number, corresponding with your level of discomfort.

0	1	2	3	4	5	6	7	8	9	10

No Discomfort *Most Discomfort*

When did this problem start?

How often do you experience this problem? Is it constant? Does it come and go? How long are the episodes when you experience it?

What makes it better?

What makes it worse?

Please describe any <u>secondary conditions</u> for which you are seeking relief:

Indicate the severity of this condition, when symptoms are <u>the worst</u>. (How bad does this condition get?)
Circle the most appropriate number, corresponding with your level of discomfort.

0	1	2	3	4	5	6	7	8	9	10

No Discomfort *Most Discomfort*

Indicate the severity of this condition, when symptoms are <u>the best</u>. (What is the least bad this condition gets?)
Circle the most appropriate number, corresponding with your level of discomfort.

0	1	2	3	4	5	6	7	8	9	10

No Discomfort *Most Discomfort*

When did this problem start?

How often do you experience this problem? Is it constant? Does it come and go? How long are the episodes when you experience it?

What makes it better?

What makes it worse?

For your primary and/or secondary complaints, please describe any therapies/treatments you have tried or are currently receiving. Please note how these treatments are working.

Please note any other problems or concerns you would like to address.

Medical History

Which of the following pertains to you? *(Check all that apply.)*

- ☐ I have a bleeding disorder.
- ☐ I am currently taking an anticoagulant (blood-thinning medication).
- ☐ I have an electrical implant such as a pacemaker, insulin pump or stimulator.
- ☐ I am pregnant, may be pregnant, or am planning to become pregnant.
- ☐ I have a seizure disorder/epilepsy.
- ☐ I have a history of cancer.
- ☐ I am currently undergoing treatment for cancer.
- ☐ I am currently undergoing treatment for hepatitis.
- ☐ I have had surgeries or hospitalizations. (List Below)
- ☐ I have needling restrictions on areas of my body. (List Below)
- ☐ I have other conditions of which my practitioner should be aware. (List Below)
- ☐ None of these apply.

Please give any details for the boxes checked above.

Which of the following do you experience? *(Check all that apply.)*

HEAD

- ☐ Headaches
- ☐ Migraines
- ☐ Facial Pain
- ☐ TMJ Pain
- ☐ Jaw Clenching/Teeth Griding
- ☐ Concussions
- ☐ Dizziness
- ☐ Vertigo
- ☐ Other (List Below)
- ☐ No problems

Details for any boxes checked above, or other non-listed problems:

SKIN & HAIR

- ☐ Normal Skin
- ☐ Dry Skin
- ☐ Hair Loss
- ☐ Dry/Brittle/Dull Hair
- ☐ Prematurely Gray Hair
- ☐ Psoriasis - Dry
- ☐ Psoriasis - Wet
- ☐ Hives
- ☐ Itchy Skin
- ☐ Scales
- ☐ Rash
- ☐ Eczema
- ☐ Acne
- ☐ Slow-Healing Wounds
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

EYES, EARS, NOSE & THROAT

- ☐ Allergies
- ☐ Sinus Pain
- ☐ Chronic Sinus Congestion
- ☐ Clear Nasal Discharge
- ☐ Yellow/Green Nasal Discharge
- ☐ Chronic Cough
- ☐ Clear Sputum
- ☐ White Sputum
- ☐ Yellow Sputum
- ☐ Dry Eyes
- ☐ Watery Eyes
- ☐ Itchy Eyes
- ☐ Red Eyes
- ☐ Gum/Teeth Problems
- ☐ Excessive Thirst/Dry Mouth
- ☐ Sore Throat
- ☐ Feeling as Though Something is Stuck in Throat
- ☐ Eye Pain
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Hearing Problems
- ☐ Ear Pain
- ☐ Ringing in Ears (High-Pitched)
- ☐ Ringing in Ears (Low-Pitched)
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

RESPIRATORY/IMMUNOLOGIC

- ☐ Frequent Colds
- ☐ Frequent Low-Grade Fever
- ☐ Current Fever
- ☐ Chills
- ☐ Asthma
- ☐ Cough
- ☐ Chest Congestion
- ☐ COPD
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Fungal Infection (Respiratory)
- ☐ Immunologic Disorder
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

CARDIOVASCULAR/HEMATOLOGICAL

- ☐ Normal Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ Cold Hands/Feet
- ☐ Ankle Swelling
- ☐ Chest Pains
- ☐ Currently Taking R_x Heart Medication (List Below)
- ☐ Pacemaker
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ History of Deep Vein Thrombosis
- ☐ Varicosities
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

NEUROLOGICAL

- ☐ Lack of Coordination
- ☐ Loss of Balance
- ☐ Poor Memory
- ☐ Numbness (List Areas Below)
- ☐ Fainting
- ☐ Twitches
- ☐ Tremors
- ☐ Seizures
- ☐ Parkinson's Disease
- ☐ Neuropathy
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

GASTRO-INTESTINAL

- ☐ Gas
- ☐ Excessive Gas
- ☐ Foul-Smelling Gas
- ☐ Belching
- ☐ Stomach Rumbling/Digestive Noises
- ☐ Pain when Hungry
- ☐ Pain after Eating
- ☐ Change in Appetite
- ☐ Bloating
- ☐ Distention of Abdomen
- ☐ Pain/Cramping
- ☐ Constant Pain
- ☐ Acid Reflux
- ☐ Burning Sensation when Lying Down
- ☐ Ulcers
- ☐ Nausea
- ☐ Vomiting
- ☐ Fatty Liver
- ☐ Gall Bladder Problems
- ☐ Difficulty Digesting Fats
- ☐ Hepatitis
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

BOWEL MOVEMENTS

- ☐ Well-Formed, Daily
- ☐ Diarrhea
- ☐ Constipation
- ☐ Watery Stools
- ☐ Loose Stools
- ☐ Soft Stools
- ☐ Hard Stools
- ☐ Dry Stools
- ☐ Foul-Smelling Stools
- ☐ With Mucous
- ☐ Blood in Stools
- ☐ Incomplete Feeling
- ☐ Hemorrhoids
- ☐ 1-2 Movements, Per Day
- ☐ 2-3 Movements, Per Day
- ☐ 3-4 Movements, Per Day
- ☐ > 4 Movements, Per Day
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

GYNECOLOGICAL/FERTILITY

- ☐ Light/Scanty Menses
- ☐ Moderate/Normal Menses
- ☐ Heavy Menses
- ☐ Dysmenorrhea - Moderate Pain
- ☐ Dysmenorrhea - Heavy Pain
- ☐ PMS Symptoms (List Below)
- ☐ PMDD Symptoms (List Below)
- ☐ Cycle Every 20-22 Days
- ☐ Cycle Every 23-25 Days
- ☐ Cycle Every 26-27 Days
- ☐ Cycle Every 28-30 Days
- ☐ Cycle Every 30-39 Days
- ☐ Cycle > 40 Days
- ☐ Irregular Cycles
- ☐ Amenorrhea (Missing Cycles)
- ☐ Spotting – Before Menses
- ☐ Spotting – After Menses
- ☐ Spotting – Between Menses
- ☐ Menstrual Discharge with Clots
- ☐ Excessive Vaginal Discharge
- ☐ Birth Control
- ☐ Inability to Conceive
- ☐ History of Failed IUI
- ☐ History of Failed IVF
- ☐ Currently Seeing Reproductive Endocrinologist
- ☐ Frequent Miscarriages
- ☐ Full-Term Delivery
- ☐ C-Section
- ☐ Miscarriages: _____
- ☐ Pregnancies: _____
- ☐ Deliveries: _____
- ☐ Prior D&C
- ☐ Menopause
- ☐ Hormone Therapy
- ☐ Pain with Intercourse
- ☐ Hysterectomy - Total
- ☐ Hysterectomy - Partial
- ☐ Oophorectomy - Partial
- ☐ Cysts/Breast Lumps
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

ENDOCRINE

- ☐ Hypo-Thyroid Disease
- ☐ Hyper-Thyroid Disease
- ☐ Pre-Diabetes
- ☐ Diabetes
- ☐ Polycystic Ovary Syndrome
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

UROLOGICAL

- ☐ Urgency to Urinate
- ☐ Frequent Urination
- ☐ Urinary Incontinence
- ☐ Painful Urination
- ☐ Incomplete Urination
- ☐ Pale Urination
- ☐ Dark Urination
- ☐ Scanty Urination
- ☐ Copious Urination
- ☐ Dribbling Urination
- ☐ Decreased Urine Flow/Pressure
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Enlarged Prostate
- ☐ Erectile Dysfunction
- ☐ Male Hormone Therapy
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

SLEEP

- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Frequent Waking due to Disturbances (partner/child/pets)
- ☐ Restlessness
- ☐ Pain Interfering with Sleep
- ☐ Waking Early
- ☐ Disturbing Dreams
- ☐ Night Sweating
- ☐ Snoring
- ☐ Night Shift Work
- ☐ Waking to Urinate 1-2 Times
- ☐ Waking to Urinate 3-4 Times
- ☐ Waking to Urinate > 4 Times
- ☐ Sleeping 8-10 Hours
- ☐ Sleeping 6-8 Hours
- ☐ Sleeping 4-6 Hours
- ☐ Sleeping < 4 Hours
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

PERSPIRATION/BODY TEMPERATURE

- ☐ Normal Perspiration
- ☐ Does Not Perspire
- ☐ Easily Perspires
- ☐ Excessive Perspiration
- ☐ Hot Flashes
- ☐ Usually Feeling Cold
- ☐ Usually Feeling Chilly
- ☐ Usually Feeling Warm
- ☐ Usually Feeling Hot
- ☐ Night Sweating
- ☐ Profuse Night Sweating
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

PSYCHOLOGICAL, MOOD & ENERGY

- ☐ Brain Fog
- ☐ Low Energy
- ☐ Fatigue
- ☐ Lethargy
- ☐ Exhaustion
- ☐ Always Tired – Waking
- ☐ Always Tired – Afternoon
- ☐ Better in the Morning
- ☐ Better in the Evening
- ☐ Jitteriness
- ☐ Anxiety
- ☐ Worry
- ☐ Fears/Phobias
- ☐ Depression
- ☐ Crying
- ☐ Mood Swings
- ☐ Irritability
- ☐ Bad Temper
- ☐ Low Sex Drive
- ☐ High Sex Drive
- ☐ ADHD
- ☐ Bipolar Disorder
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

MUSCULOSKELETAL/PAIN

- ☐ Joint Pain - Multiple Sites
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Hand Pain
- ☐ Wrist Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Elbow Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Foot Pain
- ☐ Arthritis
- ☐ Low Bone Density
- ☐ Osteoporosis
- ☐ Visceral (Internal) Pain
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems:

Pain Index _____

Please note your primary area of pain.

Check any boxes that describe the nature of your primary pain:

- ☐ N/A
- ☐ Occasional
- ☐ Intermittent
- ☐ Constant
- ☐ Achy
- ☐ Sharp
- ☐ Stabbing
- ☐ Spasm
- ☐ Fixed Pain (One Site)
- ☐ Migrating Pain
- ☐ Hot Sensation
- ☐ Cold Sensation
- ☐ Feels "Heavy"
- ☐ Worse During Day
- ☐ Worse During Night
- ☐ Better with Heat
- ☐ Better with Cold
- ☐ Better with Pressure
- ☐ Better Sitting
- ☐ Better Standing
- ☐ Better Lying Down
- ☐ Better if Moving
- ☐ Better when Walking
- ☐ Worse with Pressure
- ☐ Worse Sitting
- ☐ Worse Sitting to Standing
- ☐ Worse Standing to Sitting
- ☐ Worse Standing
- ☐ Worse Lying Down
- ☐ Worse if Sedentary
- ☐ Worse Walking
- ☐ Worse Going Up Stairs
- ☐ Worse Going Down Stairs
- ☐ Worse Bending
- ☐ Worse Lifting
- ☐ Worse Driving
- ☐ Worse with Stress

Indicate the severity of this pain, at its worst. *Circle the most appropriate number, corresponding with your level of pain.*

0	1	2	3	4	5	6	7	8	9	10

No Pain *Worst Pain*

Indicate the severity of this pain, at its best. *Circle the most appropriate number, corresponding with your level of pain.*

0	1	2	3	4	5	6	7	8	9	10

No Pain *Worst Pain*

Please provide additional information about your pain. Please include how long you've had the pain and if you've had, or are currently having, treatment for it.

Please describe the area of any secondary pain.

Check any boxes that describe the nature of your secondary pain:

- ☐ N/A
- ☐ Occasional
- ☐ Intermittent
- ☐ Constant
- ☐ Achy
- ☐ Sharp
- ☐ Stabbing
- ☐ Spasm
- ☐ Fixed Pain (One Site)
- ☐ Migrating Pain
- ☐ Hot Sensation
- ☐ Cold Sensation
- ☐ Feels "Heavy"
- ☐ Worse During Day
- ☐ Worse During Night
- ☐ Better with Heat
- ☐ Better with Cold
- ☐ Better with Pressure
- ☐ Better Sitting
- ☐ Better Standing
- ☐ Better Lying Down
- ☐ Better if Moving
- ☐ Better when Walking
- ☐ Worse with Pressure
- ☐ Worse Sitting
- ☐ Worse Sitting to Standing
- ☐ Worse Standing to Sitting
- ☐ Worse Standing
- ☐ Worse Lying Down
- ☐ Worse if Sedentary
- ☐ Worse Walking
- ☐ Worse Going Up Stairs
- ☐ Worse Going Down Stairs
- ☐ Worse Bending
- ☐ Worse Lifting
- ☐ Worse Driving
- ☐ Worse with Stress

Indicate the severity of this pain, at its worst. *Circle the most appropriate number, corresponding with your level of pain.*

0	1	2	3	4	5	6	7	8	9	10

No Pain *Worst Pain*

Indicate the severity of this pain, at its best. *Circle the most appropriate number, corresponding with your level of pain.*

0	1	2	3	4	5	6	7	8	9	10

No Pain *Worst Pain*

Please provide additional information about your pain. Please include how long you've had the pain and if you've had, or are currently having, treatment for it.

Please note any other areas of pain not covered above.

Social, Family & Personal History _____

Please provide a description for each of the following.

Living Situation:

○ Live Alone ○ Live with Roommate(s) ○ Live with Spouse/Partner ○ Live with Family

○ Other (Please Describe)

History of Significant Illness in Parents or Siblings

Diet:

○ Vegetarian ○ Vegan ○ Pescatarian ○ Gluten-Free ○ Paleo ○ Other (Please Describe)

Food Allergies or Sensitivities

Exercise – Types and Amount per Week

Alcohol Use

Tobacco Use/Smoking

Recreational Drug Use

Meditative Practice

Diet/Lifestyle Goals

Please list any Medications, Vitamins or Supplements you are taking. *(Required.)*

Please list any other questions or concerns not covered above.

Emergency Contact Name: _____

Cell Phone: ( ) _____-_____ Relationship: _____

_____ _____

Patient Signature Today's Date

_____ _____

Patient's Legal Guardian Name (if patient is a minor) Relationship

_____ _____

Patient's Legal Guardian Signature Today's Date

Thank You!