

Allexi Chiropractic, Acupuncture & Wellness Center LLC
811 Fox Lane Ste D, Waterford, WI 53185

HEALTH INFORMATION

Patient Name: _____

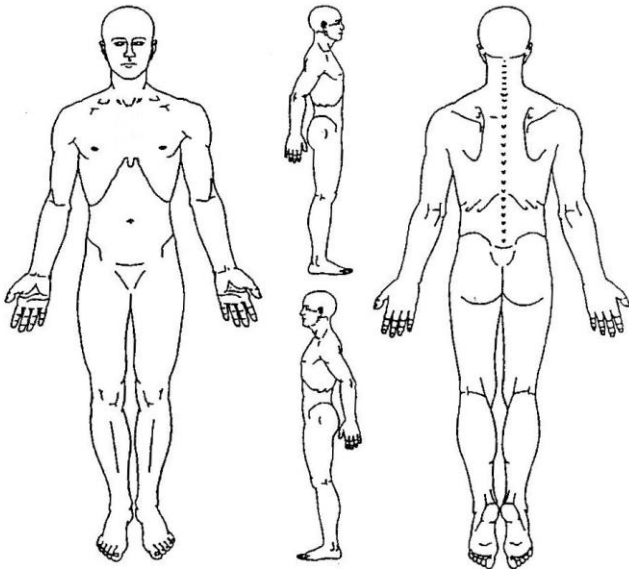
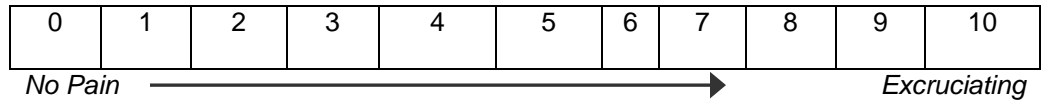
Date: _____

Have you ever received acupuncture care? Yes No When? _____
 Have you ever received chiropractic care? Yes No When? _____

Was previous care for the same reason as today's visit? Yes No

List your symptoms and when and how they began?

Circle the intensity of your symptoms:



MARK AREAS OF COMPLAINT OR PAIN

Dull: ///

Sharp: XXX

Numb: ~~~

Pins & Needles & Tingling: ***

Burning: VVV

Show Radiation of Pain or Tingling or Numbness

How often and what time of day do you experience your symptoms? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Why do you think that you are having difficulty?

What do you think you need to feel better?

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List any other care, treatments or medications that you have received for your complaints:

List any labs done and whether the results were positive or negative:

List any surgeries or serious accidents with dates:

Do you or have you ever had any of the following diseases or conditions?

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Artificial Bones / Joints |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chemotherapy / Radiation | <input type="checkbox"/> Hepatitis A, B or C |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Fibromyalgia |

List any allergens that may have caused anaphylactic reactions and when they happened:

List any other allergies that have been confirmed or suspected and describe your reactions:

List any family health history of complaints or disease and which family member was affected?

Have you ever been treated for an emotional stress problem? _____ When? _____

Are you currently in therapy? _____ Are you prone to depression? _____

Please list any nutritional supplements that you may take:

Do you wear shoe inserts? _____ What is the age of your mattress? _____ years old

For Females: Are you pregnant? Yes No Not Sure For how long? _____
Are you nursing? Yes No

*** During the course of your treatment, it is your responsibility and crucial that you inform Dr. Allexi if there is a possibility that you might be pregnant. It will alter your treatment. ***

Patient Signature: _____

Date: _____

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Please check any symptoms that you have had within the last six months.
Do not check any symptoms that are related to a common cold or flu, unless you are still ill.

GENERAL SYMPTOMS

- Headache
- Fever
- Chills
- Night Sweats
- Fainting
- Dizziness
- Seizures
- Insomnia
- Fatigue
- Nervousness
- Tumors, Cysts, Boils
- Heat Intolerance
- Cold Intolerance
- Recent Enlargement of Lymph Node
- Frequent Colds and Flu
- Sudden Weight Loss
- Recent Changes in Pigmentation
- Flushed Face
- Easily Frightened or Jumpy
- Often Thirsty
- Abnormal Lab Tests
- Excessive Sweating
- Lack of Perspiration

CARDIOVASCULAR

- Palpitations
- Irregular Heartbeat
- High Blood Pressure
- Low Blood Pressure
- Pain Over Heart
- Previous Heart Trouble
- Swelling of Ankles
- Poor Circulation
- Varicose Veins
- Strokes

RESPIRATORY

- Chronic Chest Colds
- Chronic Cough
- Chest Pain
- Excessive Phlegm
- Bronchitis
- Asthma
- Shortness of Breath
- Seasonal Allergies
- Sinus Infection

GASTROINTESTINAL

- Poor Appetite
- Poor Digestion
- Excessive Hunger
- Belching
- Heartburn
- Gas
- Nausea
- Vomiting
- Pain Over Stomach
- Diarrhea
- Constipation
- Colon Trouble
- Hemorrhoids/Rectal Pain
- Halitosis
- Use Laxatives
- Bloating/Distension
- Use Antacids

EYE • EAR • NOSE • THROAT • MOUTH

- Red Eyes
- Blurry Vision
- Eye Strain
- Spots or Floaters
- Pain/Pressure in Eyes
- Hearing Difficulties
- Ringing or Buzzing in Ears
- Ear Infections
- Lose Balance Easily
- Nasal Obstruction
- Nose Bleeds
- Loss of Sense of Smell
- Enlarged Thyroid
- Chronic Sore Throat
- Grind Teeth
- Hoarseness
- Unusual Taste in Mouth

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SKIN

- Itching
- Bruise Easily
- Dryness
- Sensitive Skin
- Hives or Allergic Skin Reaction
- Eczema
- Acne
- Dandruff

GENITOURINARY

- Frequent Urination
- Painful Urination
- Incomplete Voiding of Bladder
- Blood in Urine
- Inability to Control Urine
- Kidney Infection
- Bladder Infection
- Bed Wetting
- Prostate Trouble
- Loss of Sexual Appetite or Potency
- Venereal Disease

EXERCISE

- None Moderate
- Mild Daily

What kind of exercise?

What specific goals would you like to address with Dr. Allexi?

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

Is there anything else that you would like Dr. Allexi to know?

MUSCLES AND JOINTS

- Numbness in Arms or Hands
- Numbness in Legs or Feet
- Weakness
- Twitching
- Stiff Neck
- Backache
- Upper
- Middle
- Lower
- Pain in Arms or Hands
- Pain in Legs or Feet
- Swollen/Painful Joints
- Foot Trouble
- Hernia
- Rib Pain
- Shaking or Trembling
- Muscle Spasm

HABITS

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Sugar | <input type="checkbox"/> Amount Day |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Packs Day |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drinks Day |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Cups Day |
| <input type="checkbox"/> Decaf | <input type="checkbox"/> Cups Day |
| <input type="checkbox"/> Diet Soda | <input type="checkbox"/> Amount Day |
| <input type="checkbox"/> Reg. Soda | <input type="checkbox"/> Amount Day |
| <input type="checkbox"/> Caff. Tea | <input type="checkbox"/> Amount Day |