**Wolph Chiropractic and Acupuncture**
123 S. Main St. Fostoria, OH 419-436-0616
640 S. Wintergarden Rd. BG, OH 419-353-6394

**Name:** Last _____ First _____ SS# _____/_____/_____
**Date of Birth** _____/_____/_____ **Gender** F_____ M _____ **EMAIL**_____
**Address** _____ **City** _____ **State** _____ **Zip** _____
**Telephone:** Home (_____) _____ Cell: (_____) _____

How did you hear about our office? _____
Have you ever been treated by acupuncture or oriental medicine before? Y N

**Main Complaint**

1. Main problem you would like us to help you with: _____
2. How long ago did this problem occur: _____
3. What kinds of treatments have you tried: _____
4. Does anything improve your problem: _____

**Medications:**_____
**Allergies:**_____
**Surgeries:**_____

1. Do you have: please circle all that applies: **HIV/AIDS Hepatitis STD TB IV drug user hemophilia seizure disorder dialysis**
2. Do you have a fear of needles or would you prefer needless acupuncture? Y N
3. Are you pregnant or could you be? Y N
4. Do your symptoms occur at the same time of day/night? Y N
5. Are your symptoms chronic or is this a new condition? _____
6. Do you have a pacemaker or electrical heart device? Y N
7. Does your symptoms relate to any female hormonal issues? Y N
8. Do you have any addictions? Y N If yes please explain: _____

**ARE YOU INTERESTED IN CHIROPRACTIC CARE? Y N**

**CONSENT**

I consent to the treatment of acupuncture by Dr. Lora Wolph or Dr. Clay Wolph who are licensed in the state of Ohio to render this treatment. I understand that there may be some pain, bleeding, or electrical sensations related to this treatment. There is also a small chance that some patients may faint from the procedure. I understand that there is no guarantee as to the results and that multiple treatments may be necessary. I have had all of my questions answered to my satisfaction prior to treatment and give my full consent to treatment.

Signature: _____ Date: _____

**Please Note:** Your acupuncture treatment will require access to areas on your body, mainly the regions between your toes to knees, and fingers to elbows. Please have clean skin and wear loose clothing that provides access to these areas, and a zip up shirt for access to the trunk region if necessary. When using needles, there may be trace amounts of blood at certain points and delayed bleeding is possible. Please use the restroom prior to treatment because once treatment has started you will not be able to move around. Remain calm, relaxed and still during treatment. Questions for the doctor should be made before or after treatment. Should you feel ill or faint during treatment, inform doctor or assistant at once. Acupuncture is typically relaxing and comfortable.

## PERSONAL HISTORY

Occupation _____ Stress Level _____

Have you had any unusual stresses recently? _____

Favorite time of year (body type) _____ Worst _____

Hobbies & Recreational Habits _____

Do you have a regular exercise program? Yes ☐ No ☐ If so, please describe: _____

Have you traveled abroad in the past year? Yes ☐ No ☐ Where? _____

If applicable, please describe smoking or alcohol intake : _____

## NEUROPSYCHOLOGICAL

| | | |
|---|---|---|
| ☐ Seizures | ☐ Areas of Numbness | ☐ Anxiety |
| ☐ Concussion | ☐ Lack of Coordination | ☐ Poor Memory |
| ☐ Dizziness | ☐ Loss of Balance | ☐ Easily Angered |
| ☐ Headaches | ☐ Fainting | ☐ Depression |
| ☐ Migraines | ☐ Disorientation | ☐ Mania |
| ☐ Easily Susceptible to Stress | | |

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____ Any nervous habits? _____

## PREGNANCY & GYNECOLOGY

| | | |
|---|---|---|
| ___Age at First Menses | ___ Number of Pregnancies | ☐ Birth Control? |
| ___Period between Menses | ___ Number of Births | What type? _____ |
| ___Duration of Menses | ___Miscarriages | How long? _____ |
| ☐ Unusual Character | | ☐ Fertility Problems |
| ☐ Heavy or ☐ Light | ☐ Difficult Births | ☐ Vaginal Discharge |
| ☐ Irregular Periods | ☐ Breast Lumps | ☐ Vaginal Sores |
| ☐ Painful Periods | ☐ Clots | |

First Date of Last Menstrual Cycle _____/_____/_____ Date of Last Pap Smear _____/_____/_____

Do you experience changes in Body and/or Psyche prior to menstruation ? _____

**PLEASE CHECK IF YOU HAVE EXPERIENCED** (IN THE LAST THREE (3) MONTHS)

## GENERAL

| | | |
|---|---|---|
| ☐ Fevers | ☐ Tremors | ☐ Change in Appetite |
| ☐ Chills | ☐ Seizures | ☐ Peculiar tastes or smells |
| ☐ Fatigue | ☐ Night Sweats | ☐ Sudden energy drops? |
| What time of Day? _____ | | |
| ☐ Poor Sleep/ Insomnia | ☐ Day Sweating | ☐ Strong thirst for Hot or Cold drinks? |
| ☐ Dream Disturbed Sleep | ☐ Poor Balance | ☐ Headaches |
| ☐ Depression | ☐ Weight Loss | ☐ Localized Weakness |
| ☐ Mania | ☐ Weight Gain | ☐ Bleeding or Bruising |
| ☐ Emotional Changes | ☐ Poor Appetite | ☐ Joint Pain |

## CARDIOVASCULAR

| | | | |
|---|---|---|---|
| ☐ High blood pressure | ☐ Dizziness | ☐ Swelling of Hands | ☐ Blood Clots |
| ☐ Irregular heartbeat | ☐ Fainting | ☐ Difficulty in Breathing | ☐ Palpitations |
| ☐ Low blood pressure | ☐ Cold Sweats | ☐ Cold Hands/Feet | |
| ☐ Chest pain | ☐ Swelling of Feet | ☐ Phlebitis | |

**RESPIRATORY**

- ☐ Cough
- ☐ Asthma
- ☐ Easily Winded w/ Exertion when laying down
- ☐ Production of phlegm
- ☐ Pain w/ Deep Breaths
- ☐ Bronchitis
- What Color? _____
- ☐ Difficulty in Breathing
- ☐ Shortness of Breath
- ☐ Coughing Blood

**GASTROINTESTINAL**

- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Ulcers
- ☐ Hernia
- ☐ Abdominal Pain/ Cramps
- ☐ Parasites
- ☐ Belching
- ☐ Bad Breath
- ☐ Hemorrhoids
- ☐ Digestive Disorders
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stools

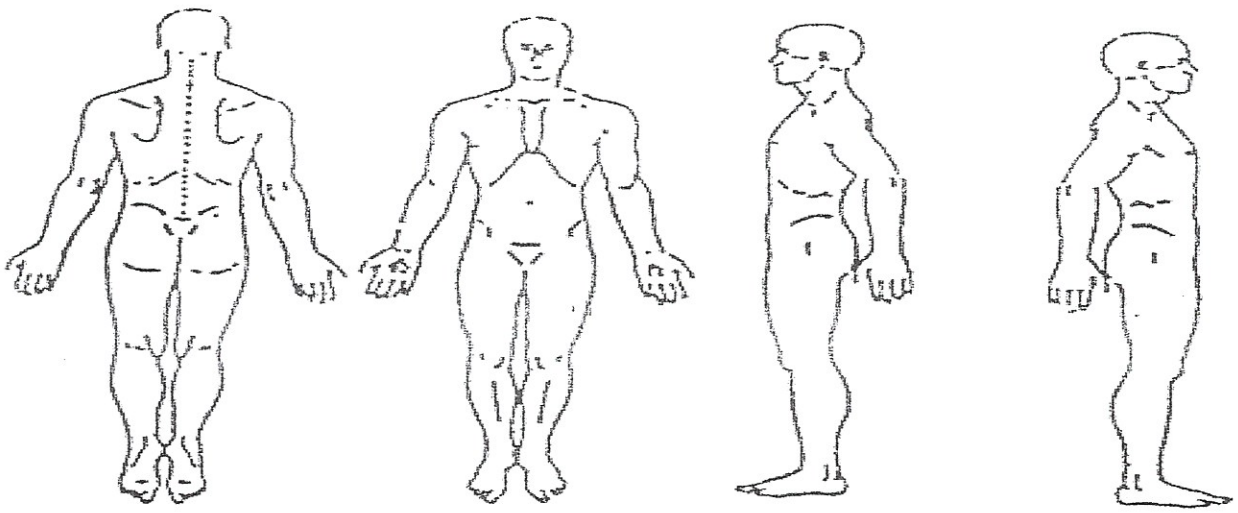
**GENITO-URINARY**

- ☐ Pain on Urination
- ☐ Urgent Urination
- ☐ Frequent Urination
- ☐ Unable to Hold Urine
- ☐ Decrease in Urine
- ☐ Blood in Urine
- ☐ Impotency/ Infertility
- ☐ Genital Sores
- ☐ Kidney sores
- ☐ Waking up to Urinate
- How often? _____

**MUSCULOSKELETAL**

- ☐ Muscular Weakness
- ☐ Muscle Cramps
- ☐ Injuries or Falls
- ☐ General Aches
- ☐ Arthritis
- ☐ Spasms
- ☐ Muscular Atrophy
- ☐ Joint Instability
- ☐ Recent Sprains

**Please circle on the diagram any areas of any type of pain or injury.**



**Please try to describe the type and quality of the pain** _____

**Please use the scale below to tell us how intense your pain is, place a circle through the number that best describes the intensity of your pain:**

0 1 2 3 4 5 6 7 8 9 10