Goldfarb Chiropractic & Acupuncture Center
1339 Pleasant Valley Way
West Orange, New Jersey 07052
Phone (973)325-8884

Date: _____ Social Security #: _____

Patient Name _____

Address _____

City, ST ZIP _____

Phone: (Home) _____ (Work) _____ (cell) _____

Date of Birth _____ (Age) _____ (Email) _____

Marital Status: (S, M, W, D) _____ Occupation _____

Emergency Contact: (Name) _____ (Phone) _____

Physician: (Name) _____ (Phone) _____

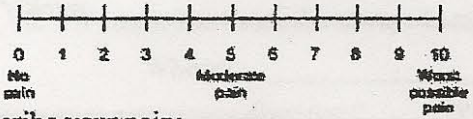
Physician's Diagnosis _____

Height _____ Weight _____

Allergies _____

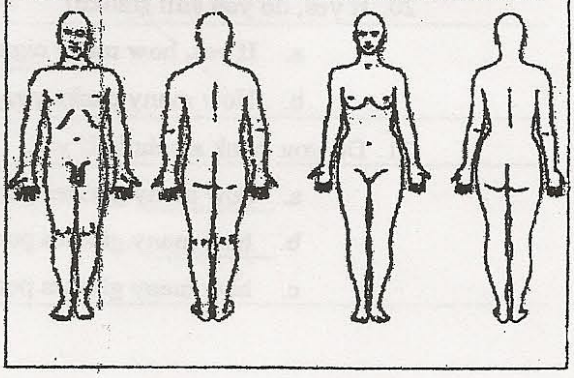
1. Have you ever had acupuncture before? Yes _____ No _____
2. Have you eaten today? _____
   a. If so, at what time was your last meal? _____
3. What is the problem that brought you here today? _____
4. Has there been anything that has ever been able to change your problem in any way?
   a. If so, please describe. _____
5. When did this problem first appear? _____
6. Is it constant or does it come and go? _____
7. If applicable, does the problem ever move? (For example, pain or spasms that occur in different joints or muscles at different times) _____
8. Do you have a history of chronic pain? Yes _____ No _____
9. Are you experiencing pain right now? Yes _____ No _____
10. If yes, what number best describes your pain? _____

0-10 Numeric Pain Intensity Scale*



11. Describe your pain:
    ☐ Dull ☐ Sharp ☐ Stabbing
    ☐ Shooting ☐ Burning ☐ Other
12. What is the frequency of the pain?
    ☐ Continuous ☐ Intermittent

Please mark your areas of pain on the diagrams below:



13. What makes your pain better? Please circle all that apply.

Heat Cold Pressure Massage Movement Rest

Other: _____

14. Is your illness affected by seasonal changes? Please describe. _____

_____

15. Are there other problems you would like addressed? _____

_____

16. Date	Medications, Vitamins & Supplements you take presently	Dosage, Route and Frequency

17. Have you had any surgeries? If yes, what type of surgery and when did you have it done? _____

_____

_____

18. History of Significant Illness:

Self: (Please include all past accidents, childhood illnesses, and the date that they occurred)

_____

_____

Siblings: _____

_____

Mother: _____

_____

Father: _____

_____

Maternal Grandmother/Grandfather: _____

_____

Paternal Grandmother/Grandfather: _____

_____

19. Have you ever smoked? Yes _____ No _____

20. If yes, do you still smoke? Yes _____ No _____ When did you quit? _____

a. If yes, how many cigarettes do you smoke daily? _____ weekly? _____

b. How many packs you smoke daily? _____ weekly? _____

21. Do you drink alcohol? If yes,

a. how many glasses per day? _____

b. how many glasses per week? _____

c. how many glasses per month? _____

22. Describe your sleep habits (for example, number of hours per night that you sleep, do you have trouble falling to sleep, or do you awake very early and are then unable to go back to sleep)_____

_____

23. Describe your bowel habits (regular, constipation, diarrhea)_____

24. If you suffer from constipation,

    a. do you feel better or worse immediately after moving your bowels? _____

    b. how many days pass before you move your bowels? _____

25. If you suffer from diarrhea,

    a. does it occur early in the morning when you first wake up?_____

    b. does your rectum burn as the stool exits? _____

    c. how many episodes of diarrhea do you have per day? _____

26. Do you regularly experience abdominal pain?_____

    a. If yes, what makes it better? Please circle all that apply.

    Heat / Cold Eating / Not Eating Rest / Movement Massage Other

27. Do you have any emotional difficulties? Please circle all that apply.

    a. Anxiety
    b. Panic Attacks
    c. Depression
    d. Mania
    e. Mood Swings
    f. Seasonal Affective Disorder

28. How would you rate your ability to concentrate/maintain focused thinking, and have clarity of thought? Please circle one choice.

    Excellent Good Fair Poor

29. How many times a day do you urinate?_____

    a. Is your urine: Clear Pale Yellow Dark Yellow
    Scant Normal Abundant

30. How would you rate your appetite?

    Excessive Moderate/Good Poor

31. Do you crave sweets? Yes _____ No _____

    a. Do you crave other foods? If yes, what type?_____

32. Do you get headaches often? Yes _____ No _____

    a. If yes, is the headache always in the same location? _____

    Where? _____

33. Do you ever experience dizziness? Yes _____ No _____

34. Are you often thirsty? Yes _____ No _____

35. Do you prefer cold, room temperature, or warm drinks?_____

36. Do you often feel cold? _____

a. If yes, where? Please circle all that apply.

Hands / Feet Limbs Entire Body Other

37. Describe the degree to which you sweat:

Very Little Average Excessive

38. Do you exercise? If yes, how often? _____

What do you do? _____

39. How would you rate your energy level?

Excellent Good Fair Poor Other

40. Describe your diet:

a. Number of vegetable portions eaten daily? _____ Weekly? _____

b. Number of meat product portions eaten daily? _____ Weekly? _____

c. Number of dairy product portions eaten daily? _____ Weekly? _____

d. Number of caffeine containing products eaten daily? _____ Weekly? _____

e. Number of whole grain product portions eaten daily? _____ Weekly? _____

41. Have you had your lymph nodes removed? If yes, please describe. _____

_____

42. Do you have any infectious diseases? _____

43. Do you have a history of drug abuse? _____

WOMEN ONLY

44. Is there a chance that you could be pregnant? _____

45. Are your menstrual cycles: Regular Irregular Early Late

46. Is your menstrual flow: Heavy Normal Light

47. Is the blood: Normal Purplish Dark Light

48. Does your menstrual blood contain clots? _____

49. Is your vaginal discharge: Clear/White and thin Yellow and Thick

50. Do you have itching or soreness of the vagina? _____

51. If you generally experience mood swings, use the choices below to describe how they are around the time of your menses. Please circle one. Better Worse Same N/A

52. Number of children _____ Number of miscarriages _____

Number of abortions _____