Acupuncture Physicians of Colorado
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Acupuncture/Osteopathic Manipulative Therapy Questionnaire

(Please Print)

Name_____ Today's Date_____

Social Security Number_____ Date of Injury_____

Date of Birth_____ AGE_____

Please provide your: Height_____ Weight_____

Workers' Compensation OR Family Primary Care Physician_____

Phone_____

Chief Complaint / Why are you here? _____

_____

_____

Briefly describe how your injury occurred. _____

_____

_____

If this was an Auto Injury-

Was your seatbelt on? _____Yes _____No

Did you lose consciousness? _____Yes _____No

Did the airbag deploy? _____ Yes _____No

Did your vehicle hit anything else after the collision? _____Yes _____ No

Did you see the accident coming (Did you brace yourself for impact?) _____Yes _____ No

What was the Make and Model of your vehicle? _____The other vehicle? _____

What was the damage to your vehicle? _____

_____

Is your pain? _____*Sharp* _____*Stabbing* _____*Cramp-like* _____*Tight* _____*Burning*

_____*Dull* _____*Achy* _____*Varies* *Other*_____

Does your pain move from place to place or radiate? _____

Do you have any numbing or tingling? Where? _____

Please list what makes your pain WORSE? _____

_____

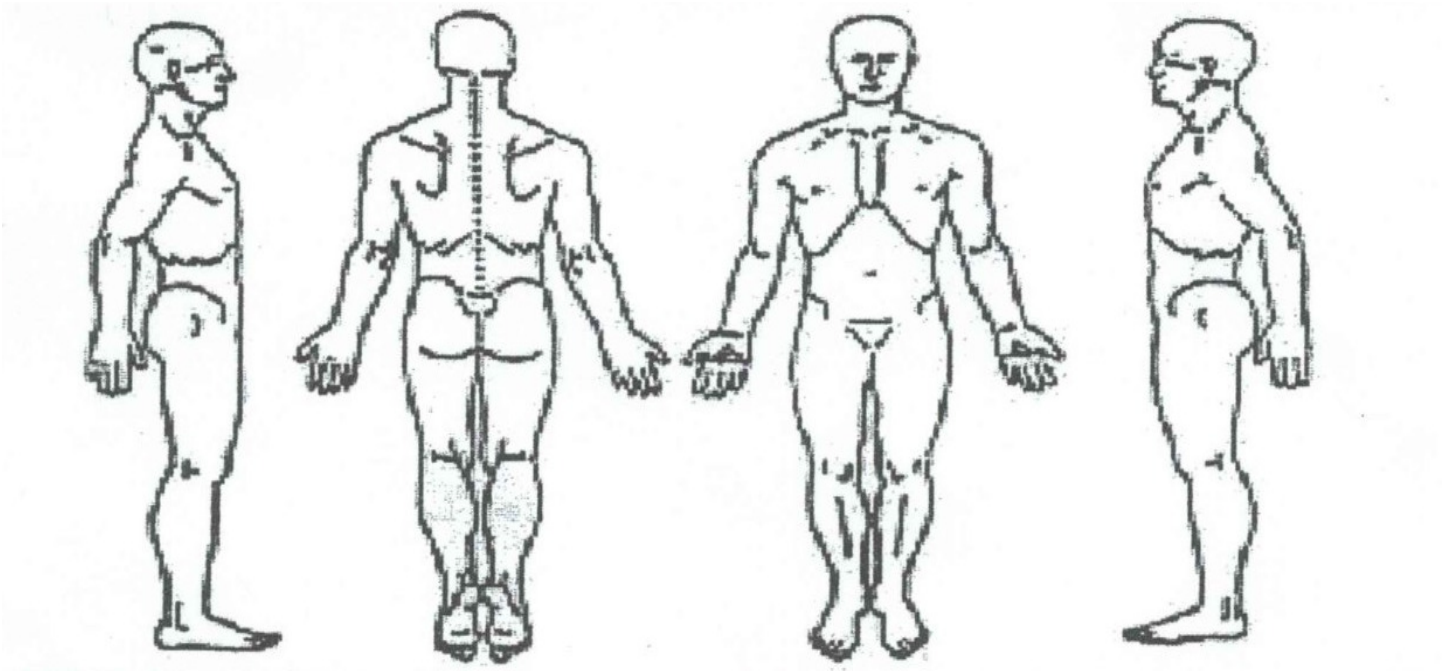
Please list what makes your pain BETTER? _____

_____

Circle a number to indicate the level of pain for this current injury. "0" on the left side of the scale represents NO PAIN and "10" on the right side of the scale represents PAIN so SEVERE it would cause you to lose consciousness or faint.

WORSE PAIN?	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
LEAST PAIN?	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
PAIN TODAY?	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

WHERE IS YOUR PAIN? (Please use the illustration below to indicate where your pain is located)



For THIS INJURY, what kind of therapy have you received?

_____ Physical Therapy _____ Acupuncture _____Massage _____Biofeedback _____ Injections

_____Osteopathic Manipulative Therapy _____Chiropractic Therapy _____Counseling

_____Other (Please Explain) _____

Exercise program and frequency: _____

List the tests you have had for THIS condition:

Type of Test	*Approximate Date*	*Done where?*
X-Rays		
CT-Scan		
MRI		
EMG		
Other:		

OCCUPATIONAL HISTORY

If you are currently working, what is your position? _____

Who is your current employer? _____

Are you currently on work restrictions? Yes _____ No _____

If this is a workers' compensation injury, who was your employer at the time of injury? _____

If this is a workers' compensation injury, what was your position at the time of injury? _____

REVIEW OF SYSTEMS

How many hours do you sleep per night?	*_____Hours*	
Do you have trouble falling asleep?	*_____Yes*	*_____No*
Do you have trouble staying asleep?	*_____Yes*	*_____No*
Do you feel well rested when you wake up	*_____Yes*	*_____No*

Please check any symptoms you have had over the past THREE MONTHS:

_____*Fatigue*	_____*Unexplained weight loss*	_____*Memory problems*	_____ *Vision problems*
_____*Headaches*	_____*Balance problems/dizziness*	_____*Depression*	_____*Anxiety*
_____*Rash*	_____*Nasal Congestion*	_____*Shortness of Breath*	_____*Chronic cough*
_____*Chest pain*	_____*Bloody or Black stools*	_____*Swollen ankles*	_____*Muscle stiffness*
_____*diarrhea*	_____*abdominal pain*	_____*Constipation*	
_____*nausea/vomiting*		_____*Urinary frequency/urgency*	

Other: _____

FOR FEMALES

_____*Menstrual problems* ***When was your last menstrual period?*** _____

IS THERE A POSSIBILITY YOU COULD BE PREGNANT? _____*Yes* _____*No*

PAST INJURIES

Have you had any other/prior on-the-job injuries? _____*Yes* _____*No*

If yes, please describe the injury AND list the date(s).

Injury ***Date***

_____

_____

Have you had any other/prior auto accident injury? _____*Yes* _____*No*

If yes, please describe the injuries AND list the date(s).

Injury ***Date***

_____

SURGERIES

_____ _____ _____

_____ _____ _____

FAMILY MEDICAL HISTORY

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY

_____*Addiction (Alcohol/Drug)*	_____*Chronic neck pain*	_____*High Cholesterol*
_____*Anemia*	_____*COPD*	_____ *HIV/AIDS*
_____*Anxiety*	_____ *Depression*	_____*Kidney disease*
_____*Arthritis*	_____*Diabetes*	_____*Liver disease*
_____*Asthma*	_____*Epilepsy/seizures*	_____*Lupus*
_____*Benign Prostate Hypertrophy*	_____*Fibromyalgia*	_____*Migraines*
_____*Cancer*	_____*Gout*	_____*Multiple Sclerosis*
_____*Chronic back pain*	_____*Environmental Allergies*	_____*Osteoporosis*
_____*Chronic constipation*	_____*Head injuries*	_____*Stroke*
_____*Chronic diarrhea*	_____*Heartburn*	_____*Thyroid Disease*
_____*Chronic digestive problems*	_____*Heart disease*	_____*TMJ*
_____*Chronic fatigue*	_____*Hemorrhoids*	*other:* _____
_____*Chronic Headaches*	_____*Hepatitis*	_____
_____*Chronic insomnia*	_____*High blood pressure*	_____

SOCIAL HISTORY

Do you presently smoke?	_____*No*	_____*Yes*	*How many packs per day?* _____
Have you ever smoked?	_____*No*	_____*Yes*	*When did you quit smoking?* _____
Do you drink alcohol?	_____*No*	_____*Yes*	*How many drinks per WEEK?* _____
Have you ever been a heavy drinker?	_____*No*	_____*Yes*	
Any recreational drug use?	_____*No*	_____*Yes*	

What is your marital status? _____*Single* ____*Married* ____*Divorced* ____*Separated*

How many children do you have? _____ *What is the last educational grade you completed?*_____

MEDICATIONS

Please list any medications you are taking:

_____

_____

_____

ALLERGIES

Please list your allergies to medications:

_____

_____