

**East Troy Acupuncture, LLC 262-642-HEAL (4325)  
3278 Main St. (P.O. Box 885) East Troy, WI 53120**

Welcome to our acupuncture clinic! We look forward to working with you to improve your health and wellness.  
Please take some time to complete this form and we will talk about your concerns during your consultation.

Some of our patients are sensitive to perfumes, colognes, etc... Thank you for not using them when you visit for appointments.

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(first) (middle) (last)  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M/F Marital status: S M D W

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thanks!**

➤ **Whom may we thank for this referral?** \_\_\_\_\_

1. When and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

2. Has your case been referred to an attorney? Y N

3. Please identify the health concern(s) that have brought you to this clinic in order of importance below:

**Condition**

**Past Treatment**

a. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

**Please Read and Sign**

*I authorize the Licensed Acupuncturist to administer acupuncture for treatment of my disorders. I understand that appointment times are reserved especially for me and that the full fee is charged for missed appointments and the half-fee for same-day cancellations. I understand that payment is due at the end of each visit unless otherwise arranged. If my private insurance covers acupuncture, I am responsible for full payment at the time of the visit.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Health History

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

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5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

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6. Do you have any reason to believe you may be pregnant?                      Y                      N

If so, how far along are you? \_\_\_\_\_

7. Do you have any infectious diseases?      Y                      N      If yes, please identify: \_\_\_\_\_

8. <b>Family History:</b>	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** \_\_\_\_\_      **Weight:** Currently: \_\_\_\_\_      Past Maximum: \_\_\_\_\_      When? \_\_\_\_\_

10. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_ / \_\_\_\_\_      When was this reading taken? \_\_\_\_\_

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever      Diphtheria      Rheumatic Fever      Mumps      Measles      German Measles      Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio      Tetanus      Measles/Mumps/Rubella      Pertussis      Diphtheria      Hib      Hepatitis B

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings                  Nervousness                  Mental Tension

15. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue                  Slow Wound Healing                  Chronic Infections                  Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision                  Eye Pain/Strain                  Glaucoma                  Glasses/Contacts                  Tearing/Dryness  
 Impaired Hearing                  Ear Ringing                  Earaches                  Headaches                  Sinus Problems  
 Nose Bleeds                  Frequent Sore Throats                  Teeth Grinding                  TMJ/Jaw Problems                  Hay Fever

17. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia                  Frequent Common Colds                  Difficulty Breathing                  Emphysema  
 Persistent Cough                  Pleurisy                  Asthma                  Tuberculosis  
 Shortness of Breath                  Other Respiratory Problems: \_\_\_\_\_

18. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease                  Chest Pain                  Swelling of Ankles                  High Blood Pressure  
 Palpitations/Fluttering                  Stroke                  Heart Murmurs                  Rheumatic Fever                  Varicose Veins

19. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers                  Changes in Appetite                  Nausea/Vomiting                  Epigastric Pain                  Passing Gas                  Heartburn  
 Belching                  Gall Bladder Disease                  Liver Disease                  Hepatitis B or C                  Hemorrhoids                  Abdominal Pain

20. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease                  Painful Urination                  Frequent UTI                  Frequent Urination                  Heavy Flow  
 Kidney Stones                  Impaired Urination                  Blood in Urine                  Frequent Urination at Night

21. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles                  Breast Lumps/Tenderness                  Nipple Discharge                  Heavy Flow  
 Vaginal Discharge                  Premenstrual Problems                  Clotting                  Bleeding Between Cycles  
 Menopausal Symptoms                  Difficulty Conceiving                  Painful Periods

22. **Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_ 4. Birth Control Type: \_\_\_\_\_ 7. # of Abortions: \_\_\_\_\_  
2. # of Days of Menses: \_\_\_\_\_ 5. # of Pregnancies: \_\_\_\_\_ 8. # of Live Births: \_\_\_\_\_  
3. Length of Cycle: \_\_\_\_\_ 6. # of Miscarriages: \_\_\_\_\_

23. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties      Prostrate Problems      Testicular Pain/Swelling      Penile Discharge

24. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain      Muscle Spasms/Cramps      Arm Pain      Upper Back Pain      Mid Back Pain  
Low Back Pain      Leg Pain      Joint Pain (if so, where?): \_\_\_\_\_

25. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness/Paralysis      Numbness/Tingling      Loss of Balance      Seizures/Epilepsy

26. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid      Hypoglycemia      Hyperthyroid      Diabetes Mellitus      Night Sweats      Feeling Hot or Cold

27. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia      Cancer      Rashes      Eczema/Hives      Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_

28. **Lifestyle:**

Do you typically eat at least three meals per day?      Y      N      If no, how many? \_\_\_\_\_

Exercise routine: \_\_\_\_\_

Spiritual practice: \_\_\_\_\_

How many hours per night do you sleep? \_\_\_\_\_      Do you wake rested?      Y      N

Level of education completed:      High School      Bachelors      Masters      Doctorate      Other

Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_      Hours/Week: \_\_\_\_\_

Do you enjoy work?      Y/N      Why/Why not? \_\_\_\_\_

Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

Have you experienced any major traumas?      Y      N      Explain: \_\_\_\_\_

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_

Interests and hobbies: \_\_\_\_\_