East Troy Acupuncture, LLC
N8030 Townline Rd. (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.

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. **I understand that appointment times are reserved especially for me and that I may be subject to a $30 same-day cancellation fee for scheduled community appointment or $45 for a private treatment. Missed appointments will be charged $40 for community and $60 for private.** *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):

_____

_____

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

_____

_____

_____

_____

_____

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. **Family History:** Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
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. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

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

Mood Swings Nervousness Mental Tension

13. **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

14. **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

15. **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: _____

16. **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

17. **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

18. **Genitourinary 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

19. **Female Reproductive** (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

20. **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: _____

21. **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

22. **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?): _____

23. **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

24. **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

25. **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? _____

_____

26. **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: _____

_____

_____

_____