# East Troy Acupuncture, LLC
# 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.

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:** | Father | Mother | Brothers | Sisters | Spouse | Children |
|---|---|---|---|---|---|---|
| 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. **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: __________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________