ABUNDANCE ACUPUNCTURE, INC.

☯ W1185 McCrae Road, Fall River, WI 53932 (920) 484-5000 ☯

"Realize the wonderful benefits of Oriental Medicine"

PLEASE FILL OUT CAREFULLY!!

Oriental Medicine often uses unusual or seemingly insignificant body changes to diagnose the cause of health problems. Some of the following questions **may not appear** to be related to your primary health problem, but your best answer to each question will provide us with the information we need to make a precise diagnosis.

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HEALTH HISTORY QUESTIONNAIRE v-2020

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

I. General Patient Information

Date: ____/____/____ Name: _____

Address: _____

City, State, Postal Code: _____

Home Phone: _(_____)_____ □Cell or □Work Phone: _(_____)_____

May we contact you: □at home, □at work, □email (provide address) _____

Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Gender: □M □F □Married □Single Height: ____'____" Weight: _____lbs.

Occupation:_____Employer:_____

Hours worked per week _____ Is your health complaint related to work? □ Yes □ No □□Maybe

How did you hear about our office? _____

Guardian (if under 18): _____

Person to notify in an emergency_____ Relationship _____

Daytime phone for above person _(_____)_____

Preferred Hospital_____ Primary Medical Doctor _____

Major Complaint(s), in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional:_____

How do these conditions impair your daily activities?_____

_____

II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

Recent tests: (please indicate test results and date below)

☐Physical	☐Cholesterol	☐Prostate	☐Blood (which?)
☐HIV/STD	☐Pap smear	☐Mammography	☐Other:_____

Abnormal Test Results and Date:_____
Check any you have had in the past:

☐Diabetes	☐Allergies	☐Glaucoma	☐Rheumatic Fever
☐Heart Disease	☐CVA (stroke)	☐Vein condition	☐Thyroid disorder
☐Asthma	☐Pneumonia	☐Tuberculosis	☐Emphysema
☐Jaundice	☐Gonorrhea	☐Mumps	☐Bleeding tendency
☐Syphilis	☐Measles	☐Chicken pox	☐Nervous disorder
☐Meningitis	☐HIV	☐Polio	☐Mononucleosis
☐Epilepsy	☐High fever	☐Hepatitis	☐Multiple Sclerosis
☐Paralysis	☐Cancer	☐Migraines	☐High blood pressure
☐Other lung illnesses	☐Other liver illnesses	☐Other heart illnesses	☐Other kidney illnesses
☐Vasectomy	☐Sleep Apnea	☐ Shingles	☐Anemia

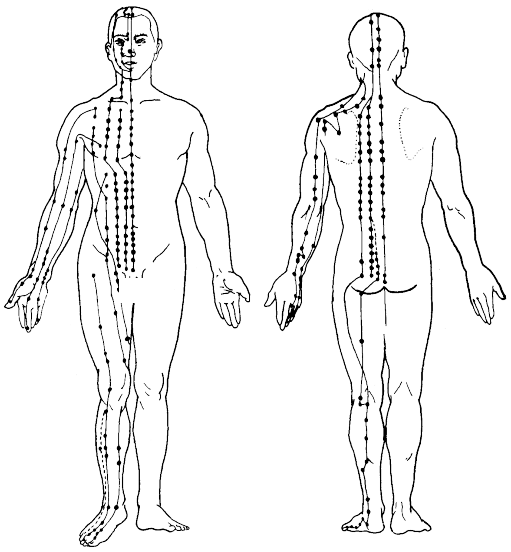
☐Other:_____

Immunizations:_____

Surgeries and Dates:_____

Serious injuries or accidents:_____

III. **Patient Profile**



Please clearly mark any areas of pain (with xxxxx's), scars (with ------) and numbness (with OOOO's).

Is the pain:

☐Sharp	☐Burning	☐Aching
☐Cramping	☐Dull	☐Moving
☐Fixed Other:_____		

Do the following lessen the pain?

☐Pressure	☐Cold	☐Heat
☐Exercise	☐Other:_____	

Do the following worsen the pain?

☐Pressure	☐Cold	☐Heat
☐Other:_____		

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function).

Overall Energy, Dampness

☐Low energy
☐General weakness
☐Difficulty keeping eyes open in the daytime
☐Feel worse after exercise
☐Overall achy feeling in the body
☐Easily catch colds
☐Low libido ☐Excessive libido
☐General sensation of heaviness in the body
☐Mental heaviness
☐Mental fogginess
☐Dizziness
☐Swollen joints (where? _____)
☐Edema (where?_____)
☐Skin is often damp or moist

Overall Temperature (Kidney function)

☐Cold body temperature (more sensitive to cold than the average person)
☐Cold sensation in the knees
☐Can get chilled to the bone (hard to get warm again)
☐Afternoon flushes
☐Night sweats
☐Heat in the hands, feet, and chest
☐Hot flashes any time of the day or night
☐Hot body temperature (sensation)
☐Alternating fevers and chills
☐Take water to bed ☐Excessive Thirst
☐Easily Perspire ☐Excessive Perspiration
☐Rarely Perspire…☐even when exercising
☐Graying Hair

Eyes, Ears, Nose, Throat

☐Headaches ☐Migraines
☐Seasonal Allergies ☐Continuous Allergies (dust, etc)
☐Sinus congestion ☐Nasal discharge ☐Sneezing
Dry: ☐lips ☐mouth ☐nose ☐throat
Eyes: ☐Itchy ☐Bloodshot ☐Dry ☐Watery ☐Gritty
☐See floating black spots ☐Decreased night vision
☐Twitch in eye(s)
☐High pitched ringing in ears
☐Low pitched ringing in ears
☐Ear aches
☐Mouth sores ☐Tongue sores ☐Bad breath
☐Bleeding, swollen, painful gums
☐Sore throat ☐Phlegm in throat
☐Difficulty Swallowing
☐Jaw Pain (TMJ)

Heart & Circulation function:

☐Mental confusion
☐Chest pain
☐Chest pain traveling to shoulder
☐Drink coffee # of cups per week: _____
☐Difficulty falling asleep
☐Difficulty keeping asleep
☐Nightmares
☐Wake unrefreshed
☐Anxiety
☐Restlessness
☐Palpitations
☐Chest tightness
☐Sores on the tip of the tongue
☐Pain radiating down the arm
☐Varicose Veins, where?_____
☐Spider Veins, where?_____

Lung function:

☐Difficulty breathing
☐Shortness of breath
☐Cough
☐Chest congestion
☐Asthma: ☐ongoing ☐in the past
☐Smoke cigarettes (# of cigarettes per day: _____)
☐Chew tobacco
☐Sadness
☐Melancholy
☐Dry Skin ☐Cracks in hands or feet
☐Sleep Apnea

Digestive Power / Stomach function:

☐Low appetite ☐Excessive appetite
☐Abrupt weight gain ☐Abrupt weight loss
☐Fatigue after eating ☐Easily bruised
☐Hemorrhoids
☐Over-thinking
☐Worry
☐Nose Bleeds
☐Other bleeding issues (describe)_____
☐Acid reflux ☐Heart burn
☐Burning sensation after eating
☐Stomach Pain ☐ Nausea ☐Vomiting
☐Abdominal bloating ☐Belching
☐Passing gas ☐Hiccoughs ☐Gurgling noise in the stomach ☐Ulcer (diagnosed)
☐Feel better after eating
☐Feel better before eating
☐Prolapsed organs (previously diagnosed, which organs? _____

Large Intestine, Small Intestine function:

☐Loose stools ☐Constipated
☐Diarrhea ☐Incomplete BM (Bowel Movement)
☐Alternating diarrhea and constipation
☐Feel worse before BM ☐Feel better before BM
☐Blood in stools
☐Mucous in stools
☐Undigested food in stools
☐Frequent BM # per day_____

Liver, Gall Bladder function:

□Anger easily □Frustration
□Depression □Irritability
□Pain in the ribs
□Tightness in the chest
□Bitter taste in the mouth
□Tingling sensation □Numbness
□Weak fingernails
Muscle: □spasms □twitching □cramping
□Recreational drugs (Which? _____)

□Gall stones (□history or □current)
□Gallbladder removed
□Seizures □Convulsions
□Skin rashes, where?_____
□Drink alcohol
□Headache at the side(s) of the head
□PMS symptoms (more detail below)
□Restless Leg Syndrome
□Exposure to toxicity
□Cold Hands □ Cold Feet

Kidney, Urinary Bladder function:

□Frequent cavities, other dental problems (past or present)
□Easily broken bones
□Weakness in low back
□Memory problems
□Excessive hair loss

□Kidney stones
□Wake during the night twice or more to urinate
□Lack of bladder control
□Fear
□Easily startled

Urination:

□Dark yellow (often)
□Reddish □Blood in Urine
□Cloudy
□Scanty
□Profuse
□Interrupted
□Weak Stream
□Sexually transmitted disease (Which? _____)

□Burning
□Painful
□Difficult
□Urgent
□Frequent
□Strong odor
□Discharge
□Bladder infections

Muscle/Skeletal

□Neck tension □Pain
□Limited Range-of-Motion in neck
□Shoulder tension □Pain
□Limited Range-of-Motion in shoulder
□Upper back tension □Pain
□Muscle weakness, where_____
□Loss of muscle function or paralysis, where_____

□Painful knees
□Weak knees
□Low back pain
□Hip pain
□Pain radiating down leg
□Pain in Hands □ Pain in Feet

Women only:

Do you experience any of the following pre-menstrual syndromes (PMS)?
How many days before period does the PMS usually start? _____days.

□nausea	□vomiting	□water retention	□breast swelling
□food cravings	□headaches	□migraines	□breast tenderness
□depression	□irritability	□anxiety	□other emotions:_____
□dull pain, where?_____		□sharp pain, where?_____	

Menstrual cycle:

□Irregular menstrual cycle……For _____□□# of years, ____ □ # of months
□Regular menstrual cycle? Pregnant?□□Yes □No
Number of children:_____ Number of pregnancies:_____
Age of first menstruation:_____ Age of menopause (if applicable):_____
Average number of days of flow:_____ Average number of days of entire cycle: ____to ____
□Severe Menstrual cramps □Bleeding between periods
□Mild Menstrual cramps □Unusual vaginal discharges (please describe)_____

Women please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (bright red, pale, brown, rusty, dark, purple, other)							
Amount of flow (heavy or light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

☐Swollen testes ☐Testicular pain ☐Impotence ☐Premature ejaculation
☐Feeling of coldness or numbness in external genitalia ☐Other_____
☐Erectile Dysfunction (ED) ☐ Vasectomy ☐Unusual discharges from the penis

Life Style Choices:

☐Drink caffeinated beverages, # per day ____ ☐Drink or use artificial sweeteners
Exercise: ☐mild ☐moderate ☐vigorous # of hours of exercise per week _____
Diet: ☐vegetarian, ☐vegan, Foods that are avoided or excluded_____

Medications Please check the box if you take any of the medications below.

☐Antacids ☐Antibiotics ☐Aspirin ☐Birth Control Pills ☐Blood Thinning Pills

☐Cortisone ☐Cough Medicine ☐Digitalis ☐Hormones ☐Insulin, Diabetic Pills

☐Iron ☐Laxatives ☐Pain Med. ☐Sleeping pills ☐Blood Pressure Med.

☐Tranquilizers ☐Vitamins ☐Water Pills ☐Weight Reduction Pills ☐Thyroid Med.

Please list all other prescriptions, over the counter medications, and supplements which you use. (if you have a written list please give it to the receptionist to be copied)

_____

_____

_____

Other Comments:_____

_____

Patient Signature:_____