

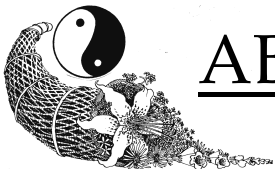
ABUNDANCE ACUPUNCTURE, INC.

☯ 119 E. Mackie Street #2, Beaver Dam, WI (920) 356-1578 ☯

"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-010

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: (____) _____ 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 (____) _____

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)

- | | | | |
|-----------------------------------|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Prostate | <input type="checkbox"/> Blood (which?) |
| <input type="checkbox"/> HIV/STD | <input type="checkbox"/> Pap smear | <input type="checkbox"/> Mammography | <input type="checkbox"/> Other: _____ |

Test Results and Date: _____

Check any you have had in the past:

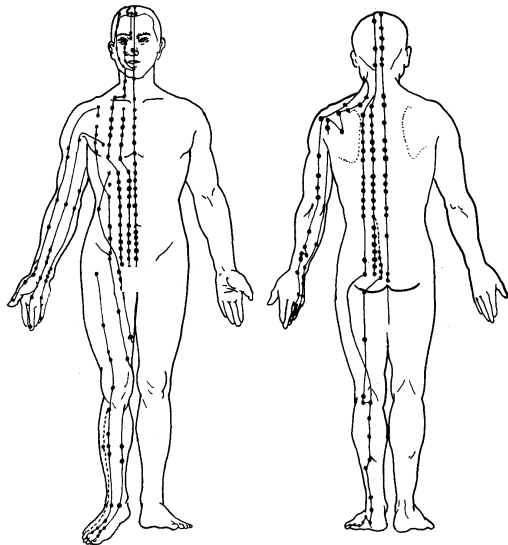
- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Other lung illnesses | <input type="checkbox"/> Other liver illnesses | <input type="checkbox"/> Other heart illnesses | <input type="checkbox"/> Other kidney illnesses |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Other: _____ | |

Immunizations: _____

Surgeries: _____

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:

- | | | |
|---|----------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Fixed Other: _____ | | |

Do the following lessen the pain?

- | | | |
|-----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ | |

Do the following worsen the pain?

- | | | |
|---------------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> 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

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

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

- 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

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) _____
- Prolapsed organs (previously diagnosed, which organs)? _____

- Acid reflux
- Heart burn
- Mouth sores
- Bad breath
- Stomach Pain
- Nausea
- Vomiting
- Abdominal bloating
- Belching
- Passing gas
- Hiccoughs
- Gurgling noise in the stomach
- Ulcer (diagnosed)
- Burning sensation after eating
- Feel better after eating
- Feel better before eating

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? _____, How much per week? _____)

- Gall stones (history or current)
- 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 _____

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

Women only:

- 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) _____

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? _____

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 _____

Medications Please check the box if taken and list specific medications if possible.

- 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.

Other medications (if you have a written list please give it to the receptionist to be copied)

Other Comments: _____

Patient Signature: _____