Acupuncture & Wellness of Wisconsin, llc

3917 47th Avenue, Kenosha, WI 53144 262-496-4626

Patient Health History Form

All information is treated as confidential unless you grant permission to release it. Please print and complete all information.

Last Name	First Name	Middle Initial	Date of birth:	Today's Date:	☐ Male ☐ Female

Address	City	State	Zip Code	Phone:	Email:

Person to notify in case of emergency:	Daytime Phone:	Relationship

Date of Last Physical Exam:	Primary Care Physician:	Physician's phone number:	Other Physicians:

Present medical symptoms:

Family History	**If Living:**		**If Deceased:**		**Any blood relatives who have or have had the listed conditions: Place a check mark next to conditions that apply.**					
	Health:		Death Age:	Cause of Death:						
	Age	Good Fair Poor			**Condition**	**Y**	**Relation**	**Condition**	**Y**	**Relation**
Mother:					Asthma			High Bl. Pressure		
Father:					Arthritis			Heart Disease		
Bothers/ Sisters: (circle sex)					Allergies			Hay Fever		
1. M F					Anxiety			Kidney Disease		
2. M F					Anemia			Leukemia		
3. M F					Alcoholism			Migraine		
4. M F					Bleeding Tend.			Hay Fever		
5. M F					Cancer: Type-			Kidney Disease		
☐ Husband ☐ Wife					Colitis			Stroke		
Sons/ Daughters (circle sex)					Congenital Heart			Suicide		
1. M F					Depression			Stomach Ulcers		
2. M F					Diabetes			Tuberculosis		
3. M F					Epilepsy			**Other Familial Conditions:**		
4. M F					Goiter					
5. M F										

Do you	**Y/N**	**Daily Consumption**	**Please list all your medications and supplements, and their purpose:**
Smoke			
Drink Coffee			
Drink Alcohol			
Fall asleep easily		Time:	
Awaken Early		Time:	

Operations you have had:	**Year**	**Diseases you have had requiring hospitalization**	**Year**	**Serious illness not requiring hospitalization**	**Year**

Allergies:

Please describe any serious injuries or accidents you have had, including the year.

Headaches:	Y	N
Do you frequently get severe headaches? (If yes, answer the following)		
Do they cause visual disturbances?		
Do they occur on one side of the head?		
Do they wake you up at night?		

Describe your headaches: (circle all that apply)

Location:	**Quality:**	**Improves with:**
Top of the head	Sharp	
"Headband"	Dull	
Temples	Constant	
Forehead	Intermittent	
Base of skull	Throbbing	
Neck	Stabbing	**Worsens with:**
Behind the eyes	Nauseating	
Other:	**Other:**	

Women's Health **Do you have/ Have you ever had:**	**Y**	**N**
Regular menstrual cycles?		
Bleeding between periods?		
Heavy bleeding?		
Currently on birth control?		
Discharge from your nipple?		
Bloated/ irritability/ PMS?		
Regular cervical cancer tests?		
Loss or change in sex drive?		
Diagnosed with an STD?		
Miscarriage? (if yes, how many?)		
How many children born alive?		
How many stillbirths?		
How many premature births?		
How many c-sections?		
Date of last menstrual period?		
Please explain any complications with pregnancy:		

Men's Health **Do you have/have you ever had:**	**Y**	**N**
Dribbling/ hesitant stream with urination?		
Loss or change in sex drive?		
Diagnosed with STD?		
Discharge from penis?		
Hernia?		
Regular prostate checks?		
Men and Women's Urinary Health: **Have you ever had:**		
Pain or burning when urinating?		
Loss of bladder control?		
Blood in the urine?		
Dark colored urine?		
Trouble starting to urinate?		
Trouble holding in urine?		
Frequent urination?		
Wake up during the night to urinate?		
If yes, how frequently?		
Passed a kidney stone?		

	Y	N
Have you ever fainted?		
Dizzy spells?		
Spells of weakness in arms/legs?		
Ringing in the ears? (circle one) High pitched Low pitched		

	Y	N
Have you ever had convulsions?		
Double vision?		
Pains in the ear?		
Nosebleeds?		

Have you had pain or tightness in the chest which begins:

When exerting yourself?		
When walking against the wind?		
When walking up a hill?		
After a heavy meal?		
When upset or excited?		
Palpitations?		

Radiates down the arm?		
Disappears when you rest?		
Occurs only when you rest?		
When walking quickly?		
When walking in cold weather?		
Do you sleep on more than one pillow?		

If you have chest pain or tightness, please explain:

Respiratory Health:
Have you ever had shortness of breath:

Doing your usual work?		
Which wakes you up at night?		
Which causes you to cough?		
Do you have a chronic cough?		
Do you smoke?		
If yes, how much per day?		

Climbing a flight of stairs?		
Accompanied by wheezing?		
When at rest?		
Do you have a history of asthma?		
Have you ever coughed blood?		
Do you have frequent sputum?		

Do you frequently have:

Bleeding gums?		
Hoarseness?		
Nausea?		

Trouble swallowing?		
A sore tongue?		
Vomiting?		

Digestive Health
Have you recently had pain in the stomach which:

	Y	N		Y	N
Occurs 1-2 hours after a meal?			Awakens you at night?		
Occurs while eating / immediately after?			Is relieved by antacids?		
Triggered by fried/ greasy food?			Is relieved by milk or eating?		
Is relieved by a bowel movement?			Causes loss of appetite?		

Bowel Health:
Do you have/ have you ever had:

Constipation?			Alternating constipation/diarrhea		
Diarrhea?					
Blood in stools?			Pain during/after passing stools?		
Mucous in stools?					
Black stools?			Ribbon-like stools?		
Light/white stools?			Pellet-like stools?		
Require regular laxatives/ softeners?			Strong foul odor?		
			Burning stools?		

Vascular Health:
Have you recently had:

Leg cramps at night?			Varicose veins?		
Pain in calves/ legs when walking?			Phlebitis/ inflamed leg veins?		
Pain in the big toe?			Swollen ankles?		

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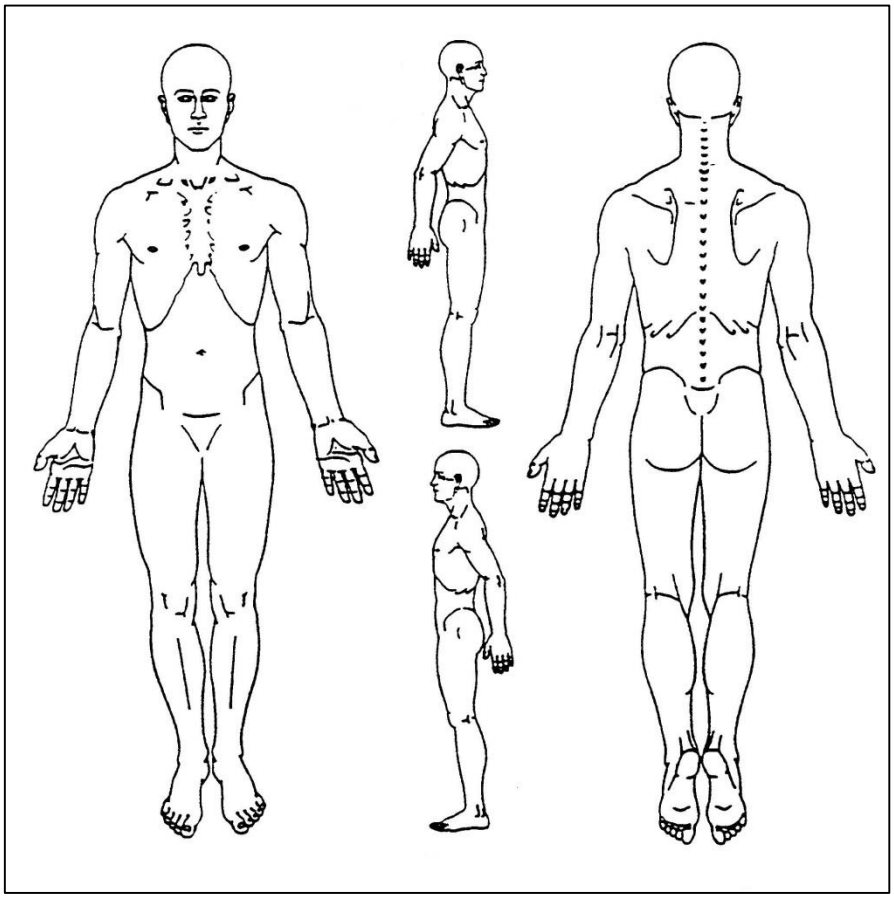
Patient Pain History Form

Name:_____ **Date:** _____

1. Please mark on the figure below where you are feeling your pain. Mark all areas that apply.

2. Describe the quality and consistency of your pain: (circle all that apply)

Sharp	Fixed (in one location)
Dull	Moves around
Tingling	Constant
Numb	Intermittent
Electric	With specific movement: (please explain)
Other:	



3. On a scale of 1 to 10, 10 being the worst, what level is your pain level *right now?* _____

4. On a scale of 1 to 10, 10 being the worst, what level is your pain *at its best?*_____

5. On a scale of 1 to 10, 10 being the worst, what is your pain level *at its worst?*_____

6. When did your pain start? _____
_____
_____
_____

7. Was there a specific incident (accident, injury, etc.) that caused your pain? If yes, what and when? _____
_____
_____

8. Pain improves with (please list everything that improves pain):_____
_____
_____

9. Pain is worse with (please list everything that worsens pain): _____
_____
_____

10. Please list any medical or holistic approaches you have used in attempt to resolve your pain (ex: chiropractor, surgery, medication, etc.): _____
_____
_____

11. Is there anything else you would like to share about your pain? _____