



Amy Rieselma, LAc., MSOM, DiplCH, DiplAc
630-335-1069

PATIENT INFORMATION

First Name _____ Last Name _____ Date _____

Email _____

Address (street) _____ City, State, Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Sex: M F Height _____ Weight _____

Marital Status: Single Married Divorced Widowed #of children _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

How did you hear about our practice? _____

Emergency Contact: _____ Phone: _____ Relation: _____

Is this your first time getting acupuncture? Yes No

HEALTH ASSESSEMENT

****Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets.****

FOCUS

What is the primary reason for seeking care at our office?

How does this problem interfere with your daily activities?

- | | | | |
|----------------------------------|----------------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Work | <input type="checkbox"/> Standing | <input type="checkbox"/> Sexually | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Emotional | <input type="checkbox"/> Recreation | _____ |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Relationships | <input type="checkbox"/> Bending | |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Social Life | <input type="checkbox"/> Stretching | |

What have you done about this up until now?

CURRENT HEALTH STATUS/CONCERNS

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
<i>i.e.: Headaches</i>	<i>May 2011</i>	<i>2 x per week</i>	<i>Acupuncture, Aspirin</i>	<i>Mild Improvement</i>

What diagnosis or explanation, if any, were you given for these concerns:

When was the last time that you felt well?

What seems to trigger and/or worsen your symptoms?

Are your symptoms better or worse with eating?

What seems to make you feel better?

What physician or other practitioner (including alternative practitioners) have you seen for these conditions?

When was your most recent bloodwork? (Include copy, if available) _____

Allergies & Sensitivities (chemical, environmental, food, drugs, etc)

List all medications (prescriptions and over the counter)

Medication Name	Date started	Dosage	What is this taken for?

List all vitamins, and any other nutritional supplements that you are taking now. If possible, indicate the dosage.

Name	Date started	Dosage	What is this taken for?

PAIN ASSESSMENT

Are you currently in pain? Yes No

Is the source of your pain due to an injury? Yes No

If yes, please describe your injury and the date in which it occurred:

If no, please describe how long you have experienced this pain and what you believe it is attributed to:

Please use the area(s) and illustration below to describe the severity of your pain.

(0= no pain, 10= severe pain)

Example: Neck

0 1 2 3 4 5 6 7 8 9 10
1

Area 1. _____

1 2 3 4 5 6 7 8 9 10

Area 2. _____

1 2 3 4 5 6 7 8 9 10

Area 3. _____

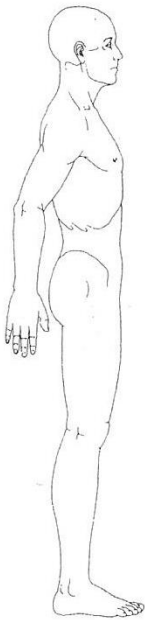
1 2 3 4 5 6 7 8 9 10

Area 4. _____

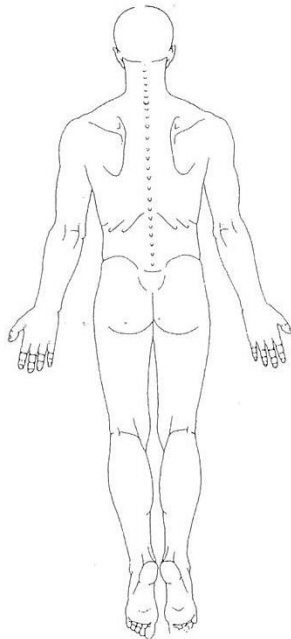
1 2 3 4 5 6 7 8 9 10

Use the letters provided to mark your area(s) of pain on the illustration.

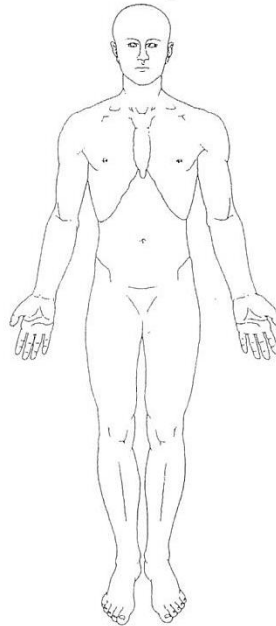
A = ache B = burning N = numbness S = stiffness T = tingling Z = sharp/shooting



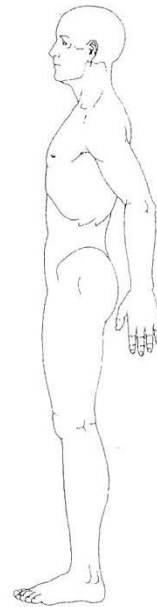
Right Side



Back



Front



Left side

NUTRITION

Do you currently follow a special diet or nutritional program? Yes No

- | | |
|-------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Ovo-lacto | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Dairy restricted | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Blood type Diet |
| <input type="checkbox"/> Other _____ | |

Meals per day ____ Snacks per day ____ Caffeinated drinks per day (1=8oz) _____

Alcoholic beverages _____ # per day/week/month/year (circle one)

Typical foods eaten on average day:

Appetite: Average appetite Always hungry Lack of appetite Feel full easily? Y/N

	Like	Dislike
Bitter	<input type="checkbox"/>	<input type="checkbox"/>
Salty	<input type="checkbox"/>	<input type="checkbox"/>
Sour	<input type="checkbox"/>	<input type="checkbox"/>
Spicy	<input type="checkbox"/>	<input type="checkbox"/>
Sweet	<input type="checkbox"/>	<input type="checkbox"/>

Thirst:

- I feel thirsty and drink a lot
 I feel thirsty and don't drink
I prefer hot or cold drinks.
 I don't feel thirsty usually

Please complete the following as it relates to your bowel movements:

Frequency: _____ per day Color: _____ (brown, green, black, etc.)

Blood Y/N? If so, In stool or on toilet paper? _____

Consistency

- | | |
|-----------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Soft and well-formed | <input type="checkbox"/> Small and hard |
| <input type="checkbox"/> Often floats | <input type="checkbox"/> Loose but not watery |
| <input type="checkbox"/> Difficult to pass | <input type="checkbox"/> Alternating - loose/watery |
| <input type="checkbox"/> Thin, long or narrow | <input type="checkbox"/> Greasy, shiny appearance |

My Bowel Movements feel Complete/Incomplete on a daily basis/most days? (circle answer)

Intestinal Gas: Y/N?

Foul odor? Y/N

LIFESTYLE

Have you ever used tobacco? Yes No

If yes, how much? _____ # of years? _____ # attempts to quit: _____

Year quit successfully _____

Are you exposed to 2nd hand smoke regularly? Yes No

Average number of hours that you sleep at night? _____

Do you:

- | | |
|-------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Have trouble falling asleep? | <input type="checkbox"/> Use sleeping aids? |
| <input type="checkbox"/> Feel rested upon waking? | <input type="checkbox"/> Sleep deeply? Sleep restlessly? |
| <input type="checkbox"/> Have Insomnia? | <input type="checkbox"/> Sleep restlessly? |
| <input type="checkbox"/> Snore? | |

Do you exercise regularly? Yes No How often? _____

What type of workout? _____ Duration of workout? _____

What problems limit your exercise activity? (lack of motivation, fatigue after exercising, etc) _____

HISTORY

Significant Trauma & Injuries (physical or emotional) _____

Significant Infant & Childhood History (for yourself -- i.e.; prolonged labor, forceps delivery, complications, cesarean, childhood diseases, etc). _____

Have you ever taken antibiotics or oral steroids for a prolonged period of time? _____

Surgeries: Include when and reason _____

-Please CIRCLE any issues you are presently having.

-Please CHECK any issues you have had in the past.

-Indicate FAMILY HISTORY by marking w/ an F for father, M for mother, S for sibling, and G for grandparent, or A/U for aunt/uncle

- | | | | |
|----------------------------------------------|--------------------------------------------------|------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Prob | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pres | <input type="checkbox"/> Hyper/Hypoglycemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Elevated Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food Allergies/Intolerances | <input type="checkbox"/> Diverticulitis/IBS |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Impotence | <input type="checkbox"/> Gastritis/Pancreatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Emphysema |

SYMPTOMS

Please CIRCLE any symptoms you are presently having.

Please CHECK any symptoms you have had in the past.

SYMPTOMS

GENERAL

- | | | | |
|---------------------------------------------|------------------------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Bleed/Bruise easily |
| <input type="checkbox"/> Weight loss/Gain | <input type="checkbox"/> Peculiar Tastes/Smells | <input type="checkbox"/> Dental/Gum Problems | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold) | | |

SKIN/HAIR

- | | | | |
|---------------------------------------------|--------------------------------------|------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Skin Discoloration | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Weak / Ridged Nails |

HEAD

- Dizziness
- Eye strain
- Color blindness
- Ringing in ears
- Nosebleeds
- Facial pain
- Sore gums
- Root canals
- Difficulty swallowing
- Eye Pain
- Cataracts
- Poor Hearing
- Recurrent Sore Throats
- Sores on lips/tongue
- Metallic taste in mouth
- Migraines
- Poor Vision
- Blurred Vision
- Spots in front of eyes
- Recurrent colds
- Jaw clicks/locks
- Bad breath
- Glasses
- Night blindness
- Earaches
- Sinus problems
- Grinding of teeth
- Headaches
- Amalgam dental fillings

CARDIOVASCULAR

- Chest pain
- Cold hands / feet
- Shortness of breath
- Low Blood Pressure
- Irregular heartbeat
- Swelling of hands/feet
- Varicose/Spider veins
- Spontaneous sweating
- Palpitations at rest
- Blood clots
- Pressure in chest
- Dizziness
- Fainting
- Phlebitis
- High Blood Pressure

RESPIRATORY

- Cough/Wheezing
- Pneumonia
- Difficulty breathing when lying down
- Coughing blood
- Pain with deep inhale
- Production on phlegm (what color?)
- Asthma
- Tight Sensation in chest
- Bronchitis
- Difficult inhale/exhale

GASTROINTESTINAL

- Nausea
- Gas
- Indigestion
- Bloating / Edema
- Changes in appetite
- Excessive appetite
- Vomiting
- Belching
- Bad Breath
- Chronic laxative use
- Acid Reflux/GERD
- Significant Thirst
- Diarrhea
- Black stools
- Rectal pain
- Loose stools (>2/day)
- Hernia
- IBS/Crohn's Disease
- Constipation
- Blood in stool
- Hemorrhoids
- Abdominal Pain/Cramps
- Poor appetite

GENITO-URINARY

- Pain on urination
- Unable to hold urine
- Sores on genitals
- Herpes infections
- Frequent urination
- Kidney stones
- Urinary Tract infection
- Night urination (what time? How often?)
- Blood in urine
- Scanty flow
- Burning urination
- Excessive Libido
- Urgent urination
- Copious flow
- Dribbling after urination
- Decreased libido

MEN ONLY

- Premature ejaculation
- Erectile dysfunction
- Prostatitis
- Nocturnal emission
- Pain in testicles

WOMEN ONLY

- Painful intercourse
- Endometriosis
- Date last PAP/exam? ____
- Infertility
- PMS
- Ovarian cysts
- Date of last menses ____
- Vaginal Discharge
- Polycystic Ovaries
- # of live births ____
- Painful period
- Age of first menses ____
- Fibrocystic breasts
- # ectopic pregnancies ____
- Diarrhea during period
- Vaginal Dryness
- Uterine fibroids
- # of pregnancies ____
- Irregular periods
- # of miscarriages ____

Birth Control _____ # of abortions _____ What type? _____ Headache during period

Insomnia during period Hot flashes Swollen breasts during period

If painful period, describe nature of pain. Also indicate before, during, or after menses (B,D,A)

Cramping _____ Burning _____ Bloating _____ Bearing down feeling _____

Consistent _____ Stabbing _____ Aching _____ Intermittent _____

Dull _____ Other _____

MUSCULOSKELETAL

Neck pain Shoulder pain Hand/Wrist pain Carpal Tunnel

Sprains/Strains Sciatica Foot/Ankle Pain Hip pain

Muscle pain Muscle weakness Tendonitis Bursitis

Back pain If yes, is it Low Middle Upper Rotator Cuff Lower body issues _____

NEUROPSYCHOLOGICAL

Seizures Loss of balance Vertigo/Dizziness Ares of Numbness

Lack of coordination Poor memory Concussion Depression

Anxiety/Panic attacks Bad temper/irritable Stressed easily SAD (seasonal affective)

Nervousness ADD/ADHD Manic Depression

Have you ever been treated for emotional problems? Yes No

Have you ever considered or attempted suicide? Yes No

Have you ever been treated for substance abuse? Yes No

Comments/Other issues? _____

REFLECTION EXERCISE

You've chosen to invest in your health – yes! Now, let's reflect on what health means to you. Use the back of this page if necessary. Take about 10-15 minutes, to sit quietly and think about. Please use the back of this page if you need more space.

1. What are my health goals? What do I hope to gain through holistic health treatments?
2. What will I feel like when I have met my health goals? (really visualize you in the future)
3. What am I willing to change about my habits, lifestyle, or mindset to achieve my goals?
4. What am I not willing to change? Why?
5. Jot down any questions you have.

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone. We look forward to helping you achieve lifelong health and well being. Sincerely, Amy Rieselman, LAc., MSOM, DiplCH, DiplAc

Notice of Privacy Practices for Energy Flow Health, Inc.

By signing this form, you acknowledge that you have been offered a copy for review of Amy Rieselmann, LAc.'s Notice of Privacy Practices (NPP). This NPP provides information about how we may use and disclose your protected health information. Our NPP is subject to change. If we change our notice, you may obtain a copy of the revised notice upon request, and if you have any questions about our NPP, please contact Amy at 630-335-1069.

X _____ Date _____
Signature of Patient or Responsible Party

MISSED APPOINTMENT POLICY

If you are unable to keep your scheduled appointment please contact us at 630-335-1069 at least 24 hours prior to your appointment time. Each appointment canceled with less than 24 hour notice, will be assessed the full appointment fee. If you arrive more than 15 minutes late for your appointment time you will be charged the full appointment fee. In the event either should happen, you authorize Energy Flow Health, Inc. to charge your credit card for this amount.

Credit Card #: _____ Exp _____
Billing Zip Code _____

Signature _____

TIPS FOR YOUR FIRST VISIT

- Please wear loose comfortable clothing that allows access to elbows and knees.
- Remove wrist accessories to allow for pulse analysis.
- Eat at least something within an hour or two of your appointment – do not have an empty stomach.
- Do not drink more than a few sips within 30-45 minutes of your appointment time.
- Of course, turn your phone to silent during your appointment.
- Remember, we are partners working together for your greater health!