Amy Rieselman, *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?

☐ Work	☐ Standing	☐ Sexually	☐ Other
☐ Sleep	☐ Emotional	☐ Recreation	_____
☐ Walking	☐ Relationships	☐ Bending	
☐ Sitting	☐ Social Life	☐ Stretching	

_____

What have you done about this up until now?

_____
_____

CURRENT HEALTH STATUS/CONCERNS

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

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._____

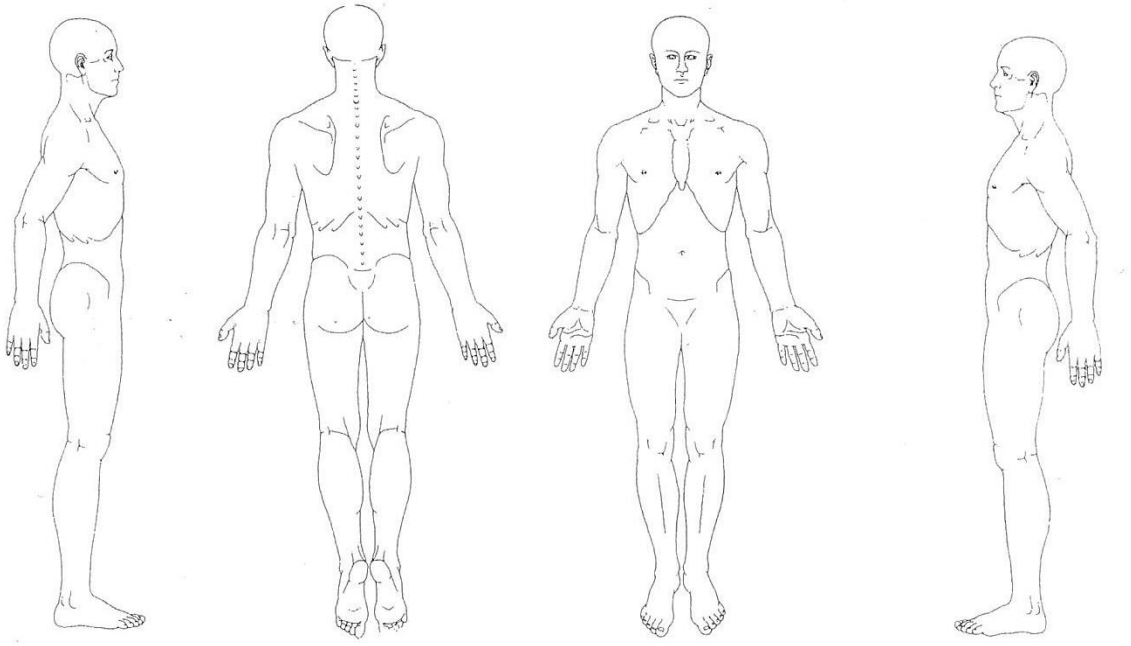
1 2 3 4 5 6 7 8 9 10

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**

- ❑ Ovo-lacto
- ❑ Dairy restricted
- ❑ Vegetarian
- ❑ Other _____
- ❑ Diabetic
- ❑ Vegan
- ❑ Blood type Diet

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	☐	☐
Salty	☐	☐
Sour	☐	☐
Spicy	☐	☐
Sweet	☐	☐

Thirst:

☐ **I feel thirsty and drink a lot**

☐ **I feel thirsty and don't drink**

I prefer ☐ **hot or** ☐ **cold drinks.**

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

- ☐ Soft and well-formed
- ☐ Often floats
- ☐ Difficult to pass
- ☐ Thin, long or narrow
- ☐ Small and hard
- ☐ Loose but not watery
- ☐ Alternating - loose/watery
- ☐ 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:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Have Insomnia?
- ❑ Snore?
- ❑ Use sleeping aids?
- ❑ Sleep deeply? Sleep restlessly?
- ❑ Sleep restlessly?

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

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

SYMPTOMS

Please CIRCLE any symptoms you are presently having.
Please CHECK any symptoms you have had in the past.

SYMPTOMS

GENERAL

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

SKIN/HAIR

☐ Rashes	☐ Ulcerations	☐ Hives/Allergic Dermatitis	☐ Itching
☐ Eczema/Psoriasis	☐ Dandruff	☐ Loss of Hair	☐ Recent moles
☐ Skin Discoloration	☐ Acne	☐ Change in skin/hair texture	☐ Face flushing
☐ Dermatitis	☐ Warts	☐ Fungal Infection	☐ Weak / Ridged Nails

HEAD

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

CARDIOVASCULAR

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

RESPIRATORY

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

GASTROINTESTINAL

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

GENITO-URINARY

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

MEN ONLY

☐ **Premature ejaculation** ☐ **Prostatitis** ☐ **Nocturnal emission** ☐ **Pain in testicles**
☐ **Erectile dysfuncion**

WOMEN ONLY

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