Madison Community Acupuncture

Medical History Form

All information is confidential and will not be shared without your written consent.
116 N Few Street, Madison WI (608)-807-6870

Name_____ Today's Date_____
Date of Birth_____ Place of Birth_____ Age _____
Address_____
Work Phone_____ Home Phone_____
Cell Phone_____ Can I text you? _____ Email_____
Can I contact you at work?_____ Can I email you?_____
Emergency Contact (name and phone #)_____
How did you hear about this clinic?_____
Do you or have you ever been diagnosed with HIV/AIDS, Hepatitis B, Hepatitis C? _____

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

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

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

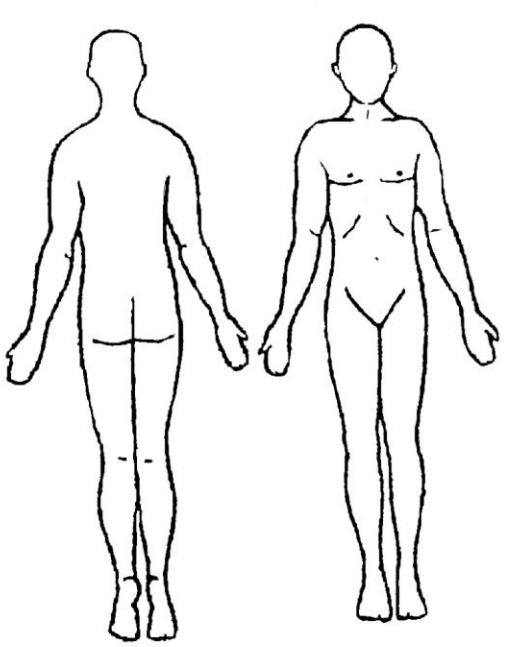
❑ other:_____
Immunizations:_____
Surgeries:_____
History of frequent antibiotic use? ❑ Yes ❑No

<u>Pain (check all that apply)</u>

- ❑ My pain is unbearable and nothing helps it
- ❑ My pain is worse at night or from inactivity
- ❑ My pain is worse in the morning
- ❑ I take prescribed medication or over the counter medication to control the pain
- ❑ I have only minor aches and pains
- ❑ I rarely, if ever experience pain

<u>Stress</u>

- ❑ My stress levels are high
- ❑ My relationship with my partner/ spouse causes me great stress
- ❑ Work is stressful & I dislike my job
- ❑ Many of my health complaints improve when I go on vacation
- ❑ I'm currently unemployed



GRID

NUMB	○ ○ ○	BURN	+ + +
ACHE	♦ ♦ ♦	PINS	|||
SHARP	Δ Δ Δ	DULL	-- -- --
MOVING	ZZZ	FIXED	❑❑❑
OTHER_____		888	

Do the following improve the pain?

❑ Pressure ❑ Cold ❑ Heat
❑ Exercise ❑ Other_____

*** Using the grid in the upper right hand portion of this page, draw the symbols on the body exactly where you are experiencing your pain***

Major Complaint(s), in order of significance to you: [Next to each complaint provide the following information: 1. How long you have been suffering with this condition? 2. How often does this complaint bother you? 3. At it's worst, describe exactly what happens or how it feels. 4. How long does it last when it is at its worst?]

Complaint(s):

(1). _____
1. _____
2. _____
3. _____
4. _____

(2). _____
1. _____
2. _____
3. _____
4. _____

(3). _____
1. _____
2. _____
3. _____
4. _____

(4). _____
1. _____
2. _____
3. _____
4. _____

(5). _____
1. _____
2. _____
3. _____
4. _____

Have you been given a diagnosis for any of the previous conditions? _____
_____
What kind of treatments have you tried, and to what extent have they helped you? _____
_____

Please list quantity and frequency of use for the following items:
Tobacco_____ per_____
Coffee_____ per_____
Alcohol_____ per_____
Sugar_____ per_____

List any recreational or street drugs you use and their frequency_____
Are you in recovery from a chemical addiction? If so, what type?_____

****Check off the smaller boxes to the left of the symptoms that apply to you within the last year.**
Ignore the date column section as they are used for follow up visits!

Date:	Date:	Date:	Date:	Date:	Date:	Date:

Thermal Perception/Overall Temperature

- ❑Frequently feel warm or experience hot body temperature (sensation)
- ❑Frequently feel cool or experience cold body temperature (sensation)
- ❑Uncomfortable feeling of heat in the body
- ❑Perspire at night or feel warm at night
- ❑Easily chilled
- ❑Hot flashes any time of the day
- ❑Feel hot in my face, chest, or hands
- ❑Perspires easily while at rest or with minimal exertion
- ❑Cold feeling in head, chest, abdomen, cold hands, genitals, or feet
- ❑Have a strong thirst for cold beverages
- ❑Have a strong thirst for hot/warm beverages or cooked food

Overall Energy

- ❑Feel worse after exercise
- ❑Difficulty keeping eyes open in the daytime
- ❑General weakness
- ❑Low energy or tired frequently
- ❑Experience an energy drop in the afternoon
- ❑I rely on caffeine to get me started in the morning
- ❑I never feel rested
- ❑I'm a "night owl"

Sleep

- ❑Difficulty falling asleep
- ❑Awaken frequently during the night (times of night:)
- ❑Pain prevents me from sleeping
- ❑Excessive sleep
- ❑Sleep deprived (sleep # hours each night)

Kidney & Urinary Bladder

- ❑Low back pain/weakness
- ❑Sore knees/weak knees
- ❑Low pitched ringing in the ears
- ❑Poor hearing
- ❑Feel afraid easily
- ❑Diminished motivation and apathy
- ❑Increased libido ❑ Diminished libido
- ❑Poor long-term memory
- ❑Have health problems that worsen in the winter
- ❑Excessive hair loss
- ❑Premature graying of hair
- ❑Crave salty foods
- ❑Frequent urination
- ❑Wake during the night twice or more to urinate
- ❑Lack of bladder control
- ❑Frequent bladder infections
- ❑History of kidney stones or Kidney stones are a current condition (please circle)

Heart & Small Intestine

- ❑Heart palpitations
- ❑Short-term memory loss
- ❑Easily confused or disoriented
- ❑Chest pain traveling to shoulder
- ❑Difficulty speaking/speech difficulties
- ❑Poor balance/bump into objects frequently
- ❑Overly sarcastic/bitter
- ❑Sadness
- ❑Do you seem low in spirit or lack vitality
- ❑Restlessness or Anxiety
- ❑Sores on mouth or tongue
- ❑Have symptoms that worsen in mid-summer

Liver & Gallbladder

- ❑Alternating diarrhea and constipation or irregular bowel movements
- ❑Hip pain
- ❑Anger easily or tend to have a “short fuse”
- ❑Frustration
- ❑Depression
- ❑Irritability
- ❑Timid
- ❑Lack of self-esteem or self-worth
- ❑Difficulty making decisions
- ❑Difficulty implementing decisions
- ❑Headaches that occur at the base of your skull
- ❑Headaches effecting your eyes or temples
- ❑Headache on the top of the head
- ❑Neck or shoulder tension
- ❑Sacrum, hip or leg tension
- ❑Sensation of having a lump stuck in your throat
- ❑High-pitched ringing in the ears
- ❑“Floaters” “seeing spots,” blurry vision, or other visual disturbances
- ❑Dry eyes
- ❑Tingling sensation or numbness
- ❑Muscle spasms, twitching, or cramping
- ❑Inflexible muscles or tight tendons
- ❑Seizures or convulsions
- ❑Have a sour or bitter taste in mouth
- ❑Crave sour or bitter flavors
- ❑Have issues that worsen in the spring
- ❑Grinding teeth or TMJ diagnosis
- ❑Brittle nails
- ❑Tight sensation in the chest
- ❑Pain beneath the ribs
- ❑Right sided pain or discomfort

Spleen & Stomach

- ❑Bruise easily
- ❑History of significant blood loss (trauma/childbirth) or donate blood regularly
- ❑Brittle and dry hair
- ❑Muscle weakness/lack strength in arms and legs
- ❑Frontal headaches
- ❑Have symptoms that worsen in late summer
- ❑Abrupt weight gain or loss in past 6 months
- ❑Hard to gain, lose, or regulate weight
- ❑Poor appetite
- ❑Crave sweets
- ❑Tend to feel tired after eating
- ❑Abdominal bloating and or gas
- ❑Painful hemorrhoids
- ❑Excessive thinking manifesting as worry or obsessive
- ❑Feel like you lack a sense of stability/centeredness

Spleen & Stomach (continued)

- ❑Sinus congestion or chest congestion
- ❑Loose stools or tend towards diarrhea
- ❑Undigested food in stools
- ❑Prolapsed organs/hernias
- ❑Varicose veins
- ❑General sensation of heaviness in the body
- ❑Mental heaviness, fogginess, sluggishness
- ❑Swollen hands
- ❑Swollen feet
- ❑Swollen joints
- ❑Burning sensation after eating/heartburn
- ❑Lingering hunger after meals
- ❑Slow digestion or indigestion
- ❑Bleeding, swollen, painful gums
- ❑Acid regurgitation
- ❑Frequent belching or hiccups
- ❑Stomach pain or tension in stomach
- ❑Vomiting

Lung & Large Intestine

- ❑Cough
- ❑Nose bleeds
- ❑Dry mouth and or throat
- ❑Dry nose
- ❑Extreme dryness of skin
- ❑Skin rashes, eczema, hives
- ❑Sore throat
- ❑Smoke cigarettes (# of cigarettes per day:)
- ❑Prone to respiratory ailments/difficulty breathing
- ❑Shortness of breath or wheezing from fatigue or exertion
- ❑Asthma
- ❑Respiratory allergies
- ❑Constant phlegm in chest and throat
- ❑Runny nose or stuffy sinuses
- ❑Health conditions that worsen in the fall
- ❑Frequently catch colds or compromised immunity
- ❑Tendency towards constipation
- ❑Foul smelling stools
- ❑Blood in stools

Men's Health

❑Swollen testes
❑Testicular pain
❑Impotence
❑Premature ejaculation

Women & Men

❑Feeling of coldness or numbness in external genitalia
❑Dark yellow urine
❑Pale colored urine
❑Frequent, scanty, or difficult urination
❑Dribbling urine

WOMEN ONLY:

Length of your cycle in days (i.e. average 28-30 days) _____ days
Average number of days of flow_____
Age of first menstruation_____
Bleeding or spotting between periods? ❑ Yes ❑No
Pregnant? ❑ Yes ❑No
Number of pregnancies _____
Unexplained Infertility? ❑ Yes ❑No
Infertility due to structural or physical origin? ❑ Yes ❑No
Diagnosis of Endometriosis? ❑ Yes ❑No
Ovarian cysts? ❑ Yes ❑No Uterine Fibroids? ❑ Yes ❑No
Hysterectomy (partial or complete) Date: _____
Are you menopausal? ❑ Yes ❑No
Do you have early menopausal symptoms? ❑ Yes ❑No
Other conditions or procedures you would like to mention _____
Do you experience any of the following pre-menstrual syndromes?
❑ nausea ❑ vomiting ❑ water retention ❑ breast swelling
❑ food cravings ❑ headaches ❑ migraines ❑ breast tenderness
❑ depression ❑ irritability ❑ anxiety ❑ other emotions:_____
❑ dull pain, where?_____ ❑ sharp pain, where?_____

Please fill in the following menstrual chart:

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

❑Feel tired after your period ❑Feel better during menses