

Confidential Health History

Ellen S. Arndorfer
Licensed Acupuncturist

ellen.arndorfer@viroquahealingarts.com

Cell: (608) 606-9083
Phone: (608) 637-7600

Name: _____	Email: _____	Date: _____
Address: _____	City: _____	State: _____ Zip: _____
Daytime phone: _____	Evening phone: _____	Cell: _____
Age: ____ Sex: ____ Height: _____	Weight: _____	Relationship Status: _____ Birthdate: _____
Employer: _____	Hrs/wk: _____	Type of Work: _____
Referred by: _____	Family MD: _____	
Emergency Contact: _____	Phone: _____	Relationship: _____

Have you ever had acupuncture before? Yes__ No__ If yes, when? ____/____/____

Reason for today's visit: _____ _____
How long have you had this condition? _____ Is it getting worse? _____
What do you feel is the cause of this condition? _____
Does it interfere with : Work _____ Sleep _____ Eating _____ Activity _____ Relating _____
What makes it feel better? _____ Worse? _____
Have you seen a physician about this? _____ When? _____
Diagnosis, if any: _____
What tests were performed and what were the results? (Include x-rays, scans, blood work, etc.) _____
Did you see anyone else about this condition? _____
What did s/he recommend? _____

What is the severity of your health concern TODAY?										
0	1	2	3	4	5	6	7	8	9	10
No problem at all					As bad as it can be					
On average, what was the typical severity of your health concern in the LAST WEEK?										
0	1	2	3	4	5	6	7	8	9	10
No problem at all					As bad as it can be					

For what else do you regularly see a doctor? (Include all diagnoses and date of onset) _____

	Describe (include dates)
Past Traumas	
Accidents	
Surgeries	
Allergies (food, medicine, etc.)	
Parents' Health	
Siblings' Health	
Children's Health	

Medications: Please note what medications, herbs or supplements that you take regularly: _____

For the following, please check all that apply to you

Energy

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Dependence on caffeine/stimulants | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hard to concentrate |
| <i>Time of day: __ am __ pm</i> | <input type="checkbox"/> Wired/ungrounded feeling | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Energy drop after eating | <input type="checkbox"/> Body / Limbs feel heavy | <input type="checkbox"/> Blood pressure High /Low | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Body / Limbs feel weak | <input type="checkbox"/> Bleed/Bruise easy | <input type="checkbox"/> Headaches |
| | | | <input type="checkbox"/> x week |

Body Temperature and Perspiration

- | | | |
|---|--|--|
| <input type="checkbox"/> Generally feel warm | <input type="checkbox"/> Generally feel cool | <input type="checkbox"/> Don't notice my body temperature |
| <input type="checkbox"/> Feel chills | <input type="checkbox"/> Feel feverish | <input type="checkbox"/> Hot flashes <input type="checkbox"/> Sweat at night |
| <input type="checkbox"/> Sweat at rest/easily | <input type="checkbox"/> Prefer hot drinks | <input type="checkbox"/> Prefer cold drinks |

Head, Ears, Eyes, Nose and Throat

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Gum Problems | <input type="checkbox"/> Glasses | <input type="checkbox"/> Poor Night Vision | <input type="checkbox"/> Excess Sputum |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Mouth Sores | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Floaters | <input type="checkbox"/> Enlarged Thyroid |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> See Halos | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Frequent Nose Bleeds |
| <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Sinus Problems | | |

Respiratory and Cardiovascular

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Chest Pain/Tightness | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Implantable Defibrillator |
| <input type="checkbox"/> Can't lie flat | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Stent | <input type="checkbox"/> Varicose Veins/Phlebitis |

Cough: dry hacking tickly recurring productive
Sputum color: clear white yellow green brown red thick thin

Diet and Thirst

After eating, feel: tired bloated energized pain gas other: _____
What do you eat: _____
What do you NOT eat: _____
Appetite: good fair poor Cravings: sweet salty meat other: _____
Eat 3 meals a day Skip meals Taste in mouth: bitter sweet metallic other: _____
Feel thirsty How much do you drink in 24 hours? _____

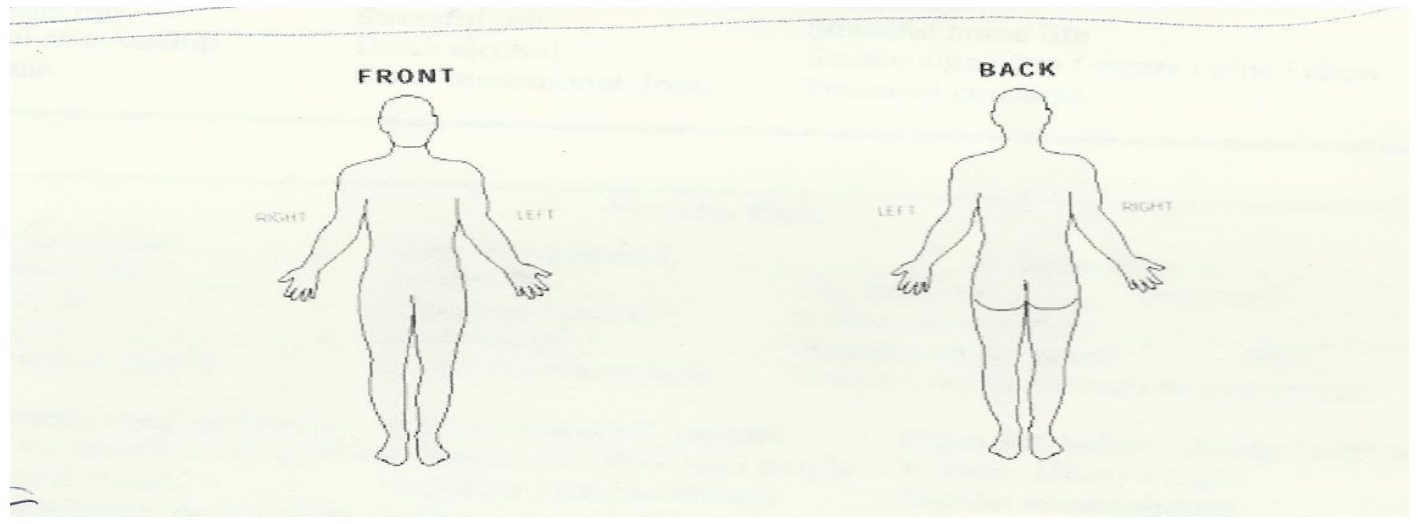
Gastrointestinal

- | | | | |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> Laxative Use | <input type="checkbox"/> Bloody Stools |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Black Tarry Stools | <input type="checkbox"/> Rectal Pain |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Intestinal Cramps | <input type="checkbox"/> Mucus in Stools | <input type="checkbox"/> Itchy / burning Anus |
- # Bowel movements per day _____ (or week _____) Texture: dry hard soft unformed watery

Genitourinary

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Burning Urination | <input type="checkbox"/> Bloody Urination | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Incomplete Urination |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Urgent Urination |
| <input type="checkbox"/> Cloudy <input type="checkbox"/> Bright <input type="checkbox"/> Dark Urine | | <input type="checkbox"/> Urinary Stones | <input type="checkbox"/> Change in Libido / Sex Drive |

Musculoskeletal Pain

 Mark the areas where you feel pain:

Skin and Hair

- Acne
- Dandruff
- Eczema
- Hives
- Itching
- Psoriasis
- Infections
- Rashes
- Ulcerations/Non-healing sores

Neuropsychological

- ADD / ADHD
- Post-Traumatic Stress
- Schizophrenia
- Currently in Therapy
- Easily Stressed
- Attempted Suicide
- Abuse Survivor
- Panic Disorder
- Bipolar
- Numbness
- Suicidal Thoughts
- Moody
- Seizures

Emotions

What emotions do you experience frequently?

- Anger
- Joy
- Sadness
- Grief
- Worry
- Indecision
- Irritability
- Fear
- Satisfaction
- Depression
- Obsessive thinking
- Calm
- Anxiety
- Timid/shy
- Content

Sleep

- Wake up rested
- Nightmares
- Nap in the day
- Hard to fall asleep
- Frequent dreaming
- "Morning" person
- Hard to get back to sleep
- Up at night to urinate
- "Night owl"
- Disturbed sleep
- Wake up easily
- Wet bed

Hours of sleep per night: _____ Quality of sleep: Excellent ___ good ___ fair ___ poor ___

Lifestyle

- Active
- Good Social network
- Healthy relationships
- Hazardous job
- Stressful relationships
- Marijuana
- Sedentary
- Feel part of a community
- Prayer
- Stressful job
- Drink alcohol
- Other recreational drugs
- Regular exercise
- Someone special in my life
- Meditation
- Stressful home life
- Smoke cigarettes / cigars / pipe /chew
- Financial concerns

Females Only

- Age periods began: _____ Date of last period: _____ Days in cycle: _____
- Past pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____
- Pregnant now ___ Trying to conceive ___ Birth control (Type: _____)
- Irritable before period ___ Bloating before period ___ Tender breasts before period ___
- Periods are: *regular* ___ *irregular* ___ *painful* ___ If painful: *before* ___ *during* ___ *after period* ___?
- Color of menstrual blood: *pale red* ___ *bright red* ___ *dark red* ___ *purple* ___ Volume: *heavy* ___ *light* ___
- Clots: *small* ___ *large* ___ Regularly examine breasts ___ Regular mammograms ___
- Date of last PAP smear: _____ Normal ___ Abnormal ___

Menopause:

- Age at last menses: _____ Hot flashes ___ a day Vaginal dryness _____
- Year changes began: _____ Night sweats ___ a week Loss of sex drive _____
- Hysterectomy ___ Hormone replacement _____

