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

____ Sudden energy drop
Time of day: __ am __pm
____ Energy drop after eating
_____Fatigue

____ Dependence on caffeine/stimulants
____ Wired/ungrounded feeling
____ Body / Limbs feel heavy
____ Body / Limbs feel weak

____ Shortness of breath
____ Heart Palpitations
____ Blood pressure High /Low
____ Bleed/Bruise easy

____Hard to concentrate
____ Poor memory
____Dizziness
____ Headaches
____x week

Body Temperature and Perspiration

____ Generally feel warm
____ Feel chills
_____Sweat at rest/easily

____ Generally feel cool
____ Feel feverish
____ Prefer hot drinks

____ Don't notice my body temperature
____ Hot flashes ____ Sweat at night
____ Prefer cold drinks

Head, Ears, Eyes, Nose and Throat

___Headaches
___Migraines
___Concussion
___TMJ
___Teeth Grinding
___Teeth Problems

___Gum Problems
___Mouth Sores
___Dry Mouth
___Poor Hearing
___Ear Aches
___Ringing in Ears

___Glasses
___Eye Strain
___Eye Pain
___Dry Eyes
___Red Eyes
___Sinus Problems

___Poor Night Vision
___Cataracts
___Floaters
___See Halos
___Glaucoma

___Excess Sputum
___Swollen Glands
___Enlarged Thyroid
___Facial Pain
___Frequent Nose Bleeds

Respiratory and Cardiovascular

___Short of Breath	___Chest Pain/Tightness	___Heart Murmur	___Implantable Defibrillator
___Can't lie flat	___Palpitations	___Pacemaker	___Blood Clots
___Wheezing	___Irregular Heart Beat	___Stent	___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

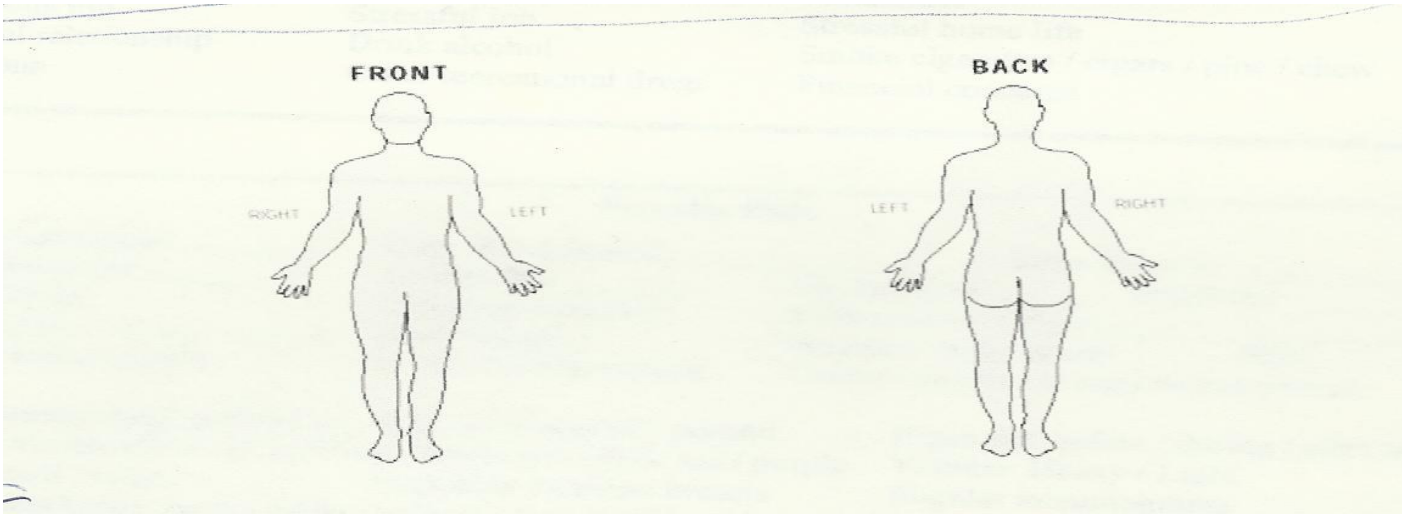
___Acid Reflux	___Trouble Swallowing	___Laxative Use	___Bloody Stools
___Bad Breath	___Heartburn	___Diarrhea	___Gallstones
___Bloating	___Nausea	___Constipation	___Hemorrhoids
___Gas	___Vomiting	___Black Tarry Stools	___Rectal Pain
___Hiccup	___Intestinal Cramps	___Mucus in Stools	___Itchy / burning Anus

Bowel movements per day ____ (or week ____) Texture: dry___ hard___ soft___ unformed___ watery___

Genitourinary

___Burning Urination	___Bloody Urination	___Painful Urination	___Incomplete Urination
___Frequent Urination	___Incontinence	___Kidney Stones	___Urgent Urination
___Cloudy ___ Bright ___ Dark Urine		___Urinary Stones	___Change in Libido / Sex Drive

Musculoskeletal Pain Mark the areas where you feel pain:



Skin and Hair

___Acne ___Hives ___Infections
___Dandruff ___Itching ___Rashes
___Eczema ___Psoriasis ___Ulcerations/Non-healing sores

Neuropsychological

___ADD / ADHD ___Easily Stressed ___Panic Disorder ___Suicidal Thoughts
___Post-Traumatic Stress ___Attempted Suicide ___Bipolar ___Moody
___Schizophrenia ___Abuse Survivor ___Numbness ___Seizures
___Currently in Therapy

Emotions

What emotions do you experience frequently?

___Anger ___Grief ___Irritability ___Depression ___Anxiety
___Joy ___Worry ___Fear ___Obsessive thinking ___Timid/shy
___Sadness ___Indecision ___Satisfaction ___Calm ___Content

Sleep

___Wake up rested ___Hard to fall asleep ___Hard to get back to sleep ___Disturbed sleep
___Nightmares ___Frequent dreaming ___Up at night to urinate ___ Wake up easily
___Nap in the day ___"Morning" person ___"Night owl" ___Wet bed

Hours of sleep per night:_____ Quality of sleep: Excellent___ good___ fair___ poor___

Lifestyle

___Active ___Sedentary ___Regular exercise
___Good Social network ___Feel part of a community ___Someone special in my life
___Healthy relationships ___Prayer ___Meditation
___Hazardous job ___Stressful job ___Stressful home life
___Stressful relationships ___Drink alcohol ___Smoke cigarettes / cigars / pipe /chew
___Marijuana ___Other recreational drugs ___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___ Bloated 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: h*eavy__ 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 ___

Males Only

Urinary

___Decrease in Flow ___Dribbling ___Difficulty starting/stopping

Reproductive

___Erectile dysfunction ___Prostate disease ___Genital Pain ___Jock Itch ___Premature ejaculation
___Vasectomy ___Sores on genitals ___Hernia ___Discharge

Sexually active? y___N___

Is there anything else you would like to share? _____

_____

ACUPUNCTURE CONSENT

I voluntarily consent to receive Acupuncture Therapy. I understand that Acupuncture is performed by the insertion of special fine needles (with or without electrical stimulation) through the skin, or the application of heat or both, to certain points on the body to regulate and balance energy and improve health.

I acknowledge that, although rare, certain side effects may result from Acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting or nausea. These effects are unusual and of short duration.

I accept that no guarantee is made concerning the use of Acupuncture and that I may discontinue treatment at any time.

I confirm that you have advised me to consult a physician regarding the conditions for which I am seeking acupuncture treatment.

I acknowledge that you are a national Board Certified Acupuncturist (NCCA) and certified by the State of Wisconsin to practice acupuncture.

_____ _____

Patient (or Patient Guardian) Date

_____ _____

Ellen Arndorfer, Licensed Acupuncturist Date