Madison Community Acupuncture

Medical History Form

All information is confidential and will not be shared without your written consent.

211 S. Paterson St, Suite 210, Madison WI (608)-807-6870

Name____ Today's Date__________________
Date of Birth______________________ Place of Birth______________________ Age ________
Address____
Cell Phone_____________________ Can I text you? ________ Email______________________________
Can I email you?____________________
Emergency Contact (name and phone #)___________________________________
How did you hear about this clinic?_______________________________________
Are you currently pregnant _______
Number of pregnancies_______ Number of children ______
Do you or have you ever been diagnosed with HIV/AIDS, Hepatitis B, Hepatitis C? _________

Health Questionnaire

Which of the following most closely matches your current health goals:

_____ **I'm only interested in relief from my symptoms.**

_____ **I'm interested in fixing the underlying cause of my current health problems.**

_____ **I'm interested in being as healthy as I can be and take an active interest in my health.**

Primary Concern

Briefly describe symptoms: ____

____

Date first noticed:______________________ **Sudden or gradual onset:** ______________________

List doctor(s) and treatments for this condition: ______________________________________

____

Is this condition affecting your: ____ **work** _____ **sleep** ____ **daily routine** ____ **other (**   **)**

List any medical diagnosis or treatment you are currently receiving:

Diagnosis	Treatment

List any allergies:

Please list quantity and frequency of use for the following items:

Tobacco___________ per__________

Coffee_____________ per__________

Alcohol_____________ per__________

Sugar______________ per__________

List nutritional supplements you are currently taking and reasons for taking them:

Supplement:	**Reason for use:**

List medications and reasons for taking them:

Medication:	**Reason for use:**

List any major illnesses, surgeries, accidents, or fractures you had:

Description:	**Date:**

Date of last medical exam: _______________ **For what reason:** ____

Date of last lab work: ____________________ **For what reason:** ____

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:____

Did you get the COVID vaccine? _____ **Which one?** ___________________________

Diagnosed with Lyme Disease: _____________________ **Date of Diagnosis:** ____________________

History of frequent antibiotic use? ❑ Yes ❑No

List any recreational or street drugs you use and their frequency_________________________

Are you in recovery from a chemical addiction? If so, what type?__________________________

Check all that apply to your current condition:

_____ **Addictions (alcohol, cigarettes, e-devices, food, money, work, vacations) circle all that apply**

_____ **Anxiety** _____ **Death of a loved one**

_____ **Depression** _____ **Domestic abuse**

_____ **Energy too little/too much** _____ **Fatigue**

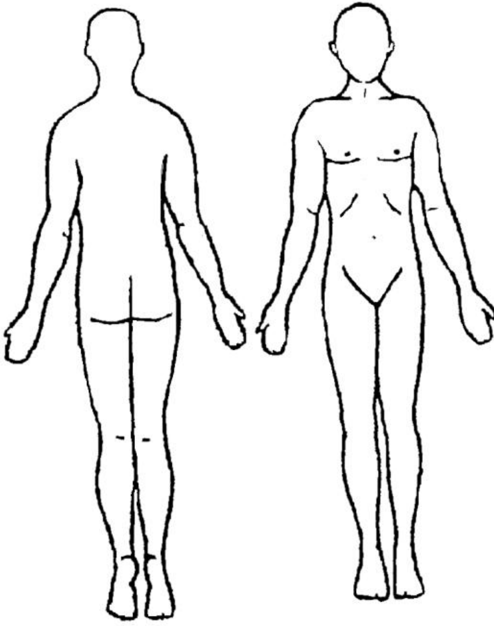
_____ **Grief** _____ **Happiness**

_____ **Relationship stress** _____ **Sleeping problems**

_____ **Stress:** ____

_____ **Suicidal thoughts & feelings**

PAIN



GRID

NUMB	○ ○ ○	BURN	+ + +
ACHE	♦ ♦ ♦	PINS	|||
SHARP	∆ ∆ ∆	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. ____

What kind of treatments have you tried, and to what extent have they helped you? ___________
____

Date of most recent x-ray/CAT scan/MRI: _________________ **For what reason:** ___________________________

Pain (check all that apply)

- ❑ 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

Stress

- ❑ 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

Do you have any other concerns that you would like me to be aware of? ________________________________

____

What are some of your dreams for life? ____

Check if true for you in the past week:

____ **Asking for help when you need it**

____ **Appreciating others**

____ **Aware of my negative thought patterns**

____ **Maintaining a balanced lifestyle**

____ **Ease in doing daily tasks**

____ **Comfortable with my emotions**

____ **Giving myself breaks**

____ **Giving and kind-hearted toward others**

____ **Grateful**

____ **Happy**

____ **Laughter**

____ **Movement**

____ **Time in nature**

____ **Paying attention to what I eat**

____ **Pooping 1-2 times daily**

____ **Satisfying food and drink**

____ **Satisfying friendships**

____ **Setting limits and boundaries**

____ **Saying what's on my mind**

____ **Stillness**