TO THE POINT ACUPUNCTURE, LLC
504 S Main St, River Falls, WI 54022
715-821-2459 tothepoint.emily@gmail.com

Health History

Your Name (first & last) Gender Date of Birth

Address City State Zip code

Phone cell/home Work phone Email

Emergency Contact Relationship Phone

Single/Married/Divorced/Widowed Occupation

Primary Physician Phone

How did you hear about our clinic? Who can we thank for a referral?

Preferred method of contact ☐ Phone ☐ Work phone ☐ Email
OK to leave a phone message? ☐ Yes ☐ No

MAJOR HEALTH COMPLAINT:

How long has this condition persisted? How did this condition develop?

Is there anything that makes it better?

Is there anything that makes it worse?

Have you received treatment for this? ☐ Yes ☐ No If yes, when?

Where? By Whom?

Diagnosis: Treatments:

Results:

SECOND HEALTH COMPLAINT:_____

How long has this condition persisted?_____How did this condition develop?_____

_____

Is there anything that makes it better?_____

Is there anything that makes it worse?_____

Have you received treatment for this? ☐ Yes ☐ No If yes, when?_____

Where?_____By Whom?_____

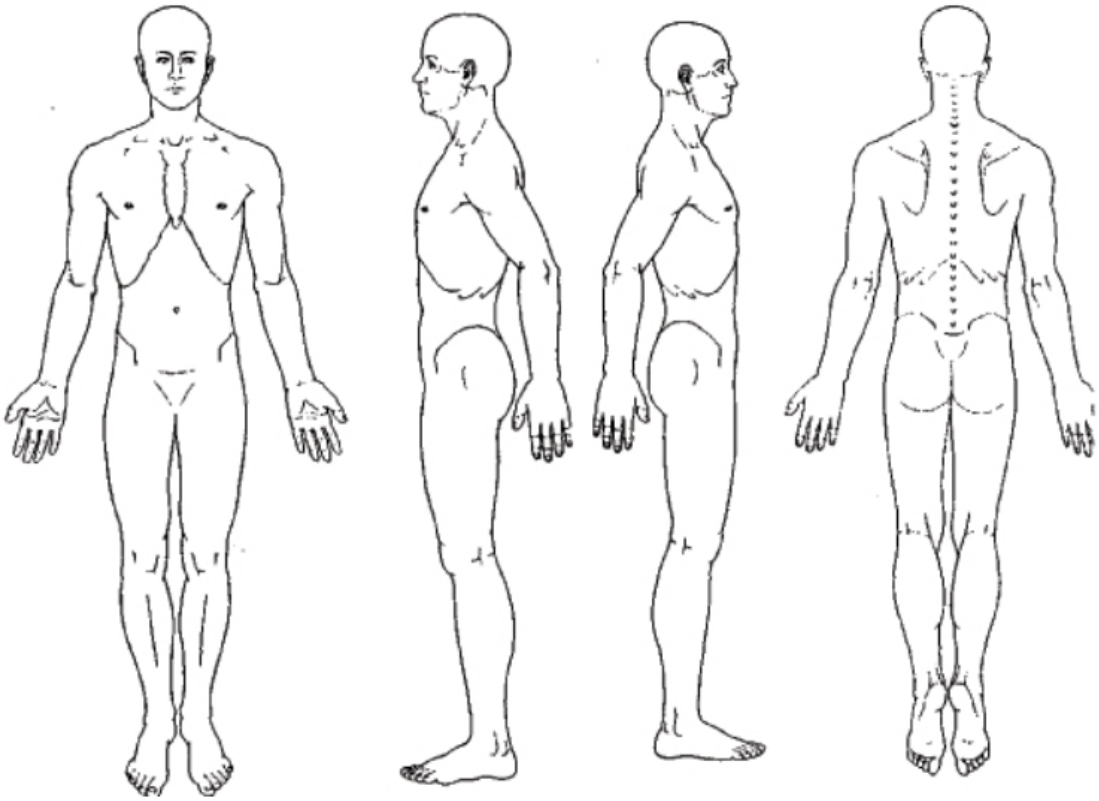
Diagnosis:_____Treatments:_____

Results:_____

SEVERITY OF PAIN – if applicable

0 1 2 3 4 5 6 7 8 9 10

Please mark areas where you are experiencing pain.



MAJOR SURGERIES:

Date Surgery Date Surgery

Date Surgery Date Surgery

SIGNIFICANT TRAUMA (auto accidents, falls, etc)_____

DATE_____ TRAUMA_____

CHILDHOOD HEALTH HISTORY (select all that pertain)

☐Allergies ☐Asthma ☐ Frequent colds/flu ☐Frequent earaches ☐Frequent sore throats

☐Premature birth ☐ Received recommended vaccinations

☐ Other significant childhood diseases_____

SIGNIFICANT ILLNESSES (select all that pertain)

Neurologic:	☐Migraines	☐Seizures	☐Epilepsy	☐Peripheral neuropathy
Mental Health:	☐Depression & Anxiety	☐Bipolar	☐PTSD	☐I am seeing a Therapist
Ear, Nose, Throat	☐Chronic Sinusitis	☐Nasal Polyps	☐Chronic Otitis Media	☐Snoring
Respiratory	☐Asthma	☐Pulmonary Embolism	☐COPD	
Cardiovascular	☐CVA	☐Heart Failure	☐Hypertension	☐Arterial Fibrillation
Gastrointestinal	☐IBS	☐GERD	☐Gallstones	☐Ulcers
Genitourinary	☐UTIs	☐Kidney Stones	☐STDs	☐BPD ☐Erectile Disfunction
Immunologic	☐Autoimmune Disease	☐Rheumatoid Arthritis	☐Hepatitis	☐HIV/AIDS
Endocrine	☐Hypothyroid	☐Hyperthyroid	☐Diabetes	

LIST CURRENT MEDICATIONS,/HERBS/SUPPLEMENTS YOU ARE TAKING:

Medication etc date began For what condition Dose

TEMPERATURE
☐Tend to feel hot
☐Tend to feel cold
☐Hot flashes
☐Acute chills
☐Acute fever
☐Vivid dreams

ENERGY
☐Too much/nervous
☐Good energy
☐Ok energy
☐Low/fatigue

THIRST
☐Thirst/drink cold
☐Thirst/drink hot
☐Thirst/don't drink
☐Not thirsty

PERSPERATION
☐Sweat little
☐Night sweats
☐Don't sweat
☐Spontaneous sweats

HEAD & SINUSES
☐Poor vision
☐Red itchy eyes
☐Poor hearing
☐Ear ringing
☐Earaches
☐Frequent headaches
☐Migraines
☐Sinus/Nasal problems
☐Poor sense of smell
☐Frequent sore throats
☐Poor teeth
☐Mouth/tongue sores
☐Lip sores
☐Dry/chapped lips
☐Dry mouth & throat
☐Dizzy/lightheaded
☐Fainting
☐Heavy head & limbs

SLEEP
☐Insomnia
☐Excessive sleep
☐Not enough sleep
☐Difficulty falling asleep
☐Difficulty staying asleep
☐Disturbing dreams
☐Sleep walk or sleep talk

LUNGS & HEART
☐Wheezing
☐Cough
☐Shortness of breath
☐Frequent colds
☐Seasonal allergies
☐Slow heart rate
☐Fast heart rate
☐Irregular heart rhythm
☐Chest pain
☐Heart palpitations
☐High blood pressure
☐Low blood pressure

MUSCULAR/ EXTREMITIES
Pain, weakness or numbness in:
☐Head
☐Neck
☐Shoulders
☐Arms/elbows
☐Wrists
☐Hands/fingers
☐Upper/mid back
☐Lower back
☐Hips
☐Legs
☐Knees
☐Ankles
☐Feet/Heels/Toes
☐Joint swelling
☐Varicose veins
☐Cold hands & feet
☐All over body pain
☐Restricted movement
☐Broken bones
☐Bone deformities
☐Paralysis

APPETITE & DIGESTION
☐Excessive appetite
☐Poor appetite
☐Excessive saliva
☐Dry mouth
☐Lump sensation in throat
☐Abdominal pain
☐Stomach aches
☐Bloating/distention
☐Gas
☐Belching/Hiccups
☐Heartburn/reflux
☐Nausea/vomit
☐Constipation
☐Loose stool/diarrhea
☐Alternating loose/consti.
☐Cramps with BM
☐BM incomplete evacuate
☐Hemorrhoids
☐Bowel incontinence

GENITOURNARY
☐Clear urine
☐Dark urine
☐Cloudy urine
☐Burning urine
☐Dribbling urine
☐Profuse urine
☐Wake to urinate
☐Incontinence
☐Difficulty urinating
☐Frequent UTI's
☐Bladder prolapse
☐Uterine prolapse

DIET & LIFESTYLE
☐Poor diet
☐Smoke cigarettes
☐Drink alcohol
☐Use drugs
☐Too little activity/exercise
☐Exercise excessively
☐Eating disorder
☐Job stress/concerns
☐Family stress/concerns
☐Other stress/concerns

MENTAL & EMOTIONAL
☐Forgetful/poor memory
☐Poor concentration
☐Irritable/angry
☐Sad
☐Tearful/weepy
☐Anxious/worried
☐Can't stop thinking
☐Fearful
☐Manic
☐Depressed
☐Hard to express emotions
☐Frequently sigh or yawn

SKIN, HAIR, NAILS
☐Thick, scaly skin/nails
☐Thin skin/nails
☐Dry skin/nails
☐Bruise easily
☐Discolored skin
☐Lumps
☐Acne
☐Abscesses/infections
☐Nail fungus
☐Premature gray hair
☐Hair loss
☐Dry/brittle hair

FAMILY HISTORY
☐Autoimmune disease
☐Cancer
☐Heart disease
☐Thyroid disorder
☐Mental illness
☐Fertility concerns

WOMEN ONLY
GYNECOLOGICAL HISTORY (if you are post menopausal, answer the best you recall)
Are you pregnant or could you be pregnant? ☐Yes ☐No

What age did menstruation begin? _____ Did you menstruate regularly? ☐Yes ☐No

If yes, how long is your cycle? _____ Do you menstruate irregularly? ☐Yes ☐No

If yes, cycle varies from _____to_____days

When was your last period?_____How many days did you bleed?_____

PMS symptoms? ☐Yes ☐No Do you have clots? ☐Yes ☐No What color is the blood?_____

Check all that apply: ☐Bowel changes ☐Breast changes ☐Acne
☐Cramps/backache ☐Food cravings ☐Nausea
☐Sad/weepy ☐Irritable/angry ☐Other_____

Are you currently using birth control? ☐Yes ☐No
If so what method are you using?_____

How many pregnancies?____ How many children?_____ How many premature births? _____

How many miscarriages?____ How many abortions?_____ Are you trying to conceive? ☐Yes ☐No

Do you have chronic vaginal discharge? ☐Yes ☐No

Do you get yeast infections regularly ☐Yes ☐No

Was your last PAP normal? ☐Yes ☐No Date _____

Have you been diagnosed with any of the following?
☐Cancer of reproductive organs? ☐PID ☐Ovarian cysts
☐Endometriosis ☐Breast cancer ☐Fibroids/Endometrial polyps

MEN ONLY
GENITOURINARY HISTORY

☐Cancer of reproductive organs	☐Coldness or numbness external genitalia	☐BPH
☐Premature ejaculation	☐Erectile disfunction	☐Date of last PSA_____
☐Number of children_____	☐Pain or swelling of testicles	