221 South First St. (Ste. A), Eagle River WI 54521
715-477-2431

Legal Name:____ Date:____/____/____

Date of Birth:____/____/____ Gender: M / F Marital status: S M D W

Number of children:___________ Ages:____

Address:____________________________ City/State/ Zip:________________________________

Phone:_____________________________ Alt. phone:__________________________________

Email address:____
Do you give permission to call you and leave a message regarding treatment if necessary? Yes No

Employer:___________________ Occupation:_________________ Phone:_____________________

Emergency Contact:__________________ Relationship:________________ Phone:______________

Successful health care and preventative medicine are made possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you

1. Please identify the health concerns that have brought you to Gentle Healing Acupuncture, LLC in order of importance below:

Condition	**Past Treatment**
a.____________________________________	______________________________________
b.____________________________________	______________________________________
c.____________________________________	______________________________________
d.____________________________________	______________________________________

2. If applicable, please list any foods or medications which you are hypersensitive or allergic to (please include reaction):

____

____

3. Please list any medications (prescribed or over-the-counter), vitamins, and supplements you are currently taking:

____

____

____

4. Have you been treated for any health conditions in the past year? Y N

If yes, please explain:____

5. Have you experienced any major illness or trauma at any time in your life? Y N

If yes, please explain:____

6. Do you have a pacemaker? Y N

7. Do you have any artificial components in your body? (i.e. knee/hip replacement, screws/plates) Y N

If yes, please list: ____

8. Do you have any infectious diseases? Y N

9. Has anyone in your family had cancer or heart disease? Y N

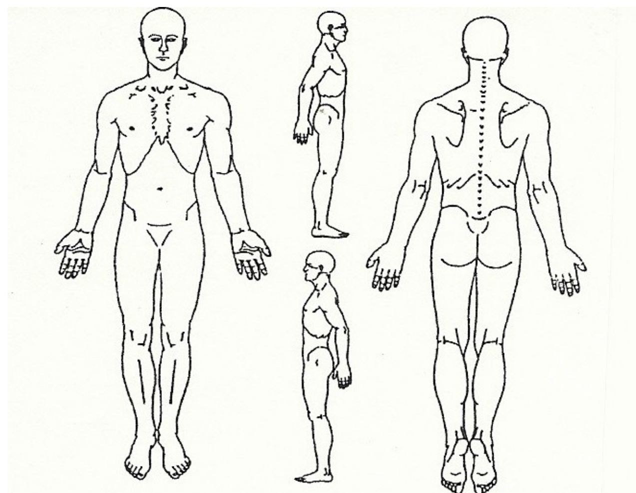
If yes, please explain:____

10. **Musculoskeletal** (please circle any you experience now and underline any that you have experienced in the past):

Low back pain Pain between shoulders Neck pain Hip Pain

Joint Pain/Stiffness Walking problems Difficulty chewing Jaw Clicking

Please indicate areas on your body which you feel pain/numbness:



11. **Neurologic** (please circle any you experience now and underline any that you have experienced in the past):

Numbness Dizziness Loss of Balance Fainting

Confusion Forgetfulness Convulsions Paralysis

12. **Cardiovascular** (please circle any you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Heart Murmur High Blood Pressure

Palpitations Irregular Heart Beat Ankle Swelling Varicose veins

13. **Respiratory** (please circle any you experience now and underline any that you have experienced in the past):

Difficult breathing   Persistent cough   Frequent colds   Pneumonia

Asthma   Emphysema   Tuberculosis   Shortness of breath

Other:____

14. **Gastrointestinal** (please circle any you experience now and underline any you have experienced in the past):

Change in Appetite   Nausea/Vomiting   Abdominal Pain   Acid Reflux(Heartburn)

Ulcers   Gas   Constipation   Hemorrhoids

Other:____

15. **Genito-Urinary** (please circle any you experience now and underline any you have experienced in the past):

Kidney Disease   Kidney Stones   Frequent UTI   Frequent Urination

Painful Urination   Impaired Urination   Blood in Urine   Urgent Urination

16. **Head, Eye, Ear, Nose, and Throat** (please circle any you experience now and underline any that you have experienced in the past):

Dry/Watery eyes   Impaired Vision Eye Pain/Strain   Glaucoma

Impaired Hearing   Ear Ringing   Earaches   Headaches

Sinus Congestion   Nose Bleeds   Allergies   Jaw Problems

17. **Endocrine** (please circle any you experience now and underline any that you have experienced in the past):

Hypothyroid   Hyperthyroid   Hypoglycemia   Diabetes Mellitus

Other:____

18. **Emotional** (please circle any you experience now and underline any that you have experienced in the past):

Depression   Anxiety   Stress   Nervousness

Other:____

19. **Other** (please circle any you experience now and underline any you have experienced in the past):

Liver Disease   Gallbladder Disease   Skin conditions   Addictive Disorder

20. **Female Only** (please circle any you experience now and underline any you have experienced in the past):

Breast Lumps Breast Tenderness Nipple Discharge Irregular Cycles

Spotting Painful Periods Premenstrual Symptoms Menopausal Symptoms

Difficulty Conceiving Vaginal Pain Vaginal Discharge Vaginal Infections

Is there any chance that you are pregnant? Y N

If so, how far along are you? ______________________

Age of first Menses:_____________ Number of days of menses:______________

Length of Cycle:________________ Type of Birth Control:___________________

Number of Pregnancies:_________ Number of Live Births:__________________

Number of Miscarriages:_________ Number of Abortions:___________________

21. **Male Only** (please circle any you experience now and underline any you have experienced in the past):

Prostate Concerns Sexual Dysfunction Penile Discharge Testicular Pain/Swelling

Painful/Frequent/Decreasing Urination Discolored Urine

22. Please list any health condition(s) you experience which was not listed here:

How did you hear about us? ____

Signature: ____ Date: ____________________