Seasons of Balance Family Acupuncture, LLC
1106 4th Ave Woodruff, WI 54568

Patient Medical History

Patient name _____ Date _____
Patient address _____
City_____ State_____ Zip code_____
Parent(s)/legal guardian name(s) if patient is a child _____
Primary contact phone _____ (check one) Home__ Cell__ Work __
May we leave a message? _____
Email address _____
Gender: Male __ Female __ Age _____ Date of Birth ____/____/____
Weight _____ Height _____ Occupation _____
Primary care physician _____ Phone number ( )_____
Date of last visit _____ Reason _____
Have you received acupuncture in the past? __Yes__No Reason_____
Name of Acupuncturist_____ Date of last visit _____

Emergency contact
Name _____ Relationship _____
Phone number ( )_____

Primary complaint
What is the main reason for this visit?
_____
_____

Approx. date complaint started _____
Where/how did symptoms begin? _____
_____
Is there a pattern to when the symptoms occur? __Yes __No If yes, what is the pattern:
__In the morning __Occasionally __During sleep
__In the evening __Intermittently __Upon waking
__All day __Constantly __Other _____
What makes the symptoms worse? _____
What makes the symptoms better? _____
Have you received other treatment for this complaint? __Yes __No
If yes, what was done? _____
Did it help? __Not at all __Somewhat __Very effective __Not sure
Have any other family members had the same or similar complaint? __Yes __No

Personal history

How would you describe your health as a child? _____

_____

Check any illnesses or conditions you have or have had in the past:

__AIDS/HIV	__Alcoholism	__Allergies	__Antibiotic use
__Asthma	__Bleeds easily	__Cancer	__Chicken pox
__Diabetes	__Enlarged organ(s)	__Epilepsy	__Glaucoma
__Heart disease	__Hepatitis	__High blood pressure	__High fevers
__Jaundice	__Kidney disease	__Measles	__Meningitis
__Mental disorder	__Multiple sclerosis	__Mumps	__Pneumonia
__Polio	__Rheumatic fever	__Scarlet fever	__Shingles
__Skin conditions	__Stroke	__Thyroid disorders	__Tuberculosis
__Typhoid fever	__Ulcers	__Vascular disease	__ Venereal disease

__Other _____

Check the diseases for which you have been immunized:

__Diptheria/Pertussis/Tetanus	__Chicken pox	__Shingles
__Measles/Mumps/Rubella	__Hepatitis B	__Influenza

__Other _____

Have any of these vaccinations been in the last 3 months? __Yes __No

List illnesses for which you have been hospitalized:_____

_____

List illnesses/injuries which have required surgery:_____

_____

List any other serious injury, broken bones, scars, etc. _____

_____

List allergies or sensitivities to any medications or other substances: _____

_____

Date of your last medical physical _____

Any abnormal findings/concerns? _____

_____

List medications (prescription and over the counter) and supplements

Name	Dosage	Reason for taking

Family History

Father __Living __Deceased Age/Age at death____ Cause_____

Mother __Living __Deceased Age/Age at death____ Cause_____

Other parent __Living __Deceased Age/Age at death____ Cause_____

Spouse __Living __Deceased Age/Age at death____ Cause_____

Sibling(s) Health status_____

Children Health status_____

List any major health concerns that run in your family (blood relatives): _____

_____

Other

Comments (anything else you would like to tell me): _____

_____

_____

Do you have any specific questions you would like to discuss today? _____

_____

_____

I authorize treatment by Vanessa Tippett L.Ac. at Seasons of Balance Family Acupuncture, LLC. All information on this form is correct.

Patient Signature _____ **Date** _____

Consent to treat a minor child: I hereby authorize Vanessa Tippett L.Ac. to administer treatment to my child, _____

Parent/Legal Guardian Signature_____ **Date** _____