Seasons of Balance Family Acupuncture, LLC
8650 US Hwy 51 N Minocqua, WI 54548

Patient Medical History

Patient Name: _____ **Date:** _____

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? Y N If yes, what is the pattern:

__Constantly __During sleep __Upon waking __In the morning

__In the evening __All daytime only __Occasionally __Other_____

What makes the symptoms worse? _____

What makes the symptoms better?_____

Have you received treatment for this complaint? Y N

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? Y N

Personal History

How would you describe your health as a child? _____

_____

Have you had any vaccinations in the last 3 months? Y N

If yes, which one(s)? _____

List illnesses for which you have been hospitalized: _____

_____

List illness/injuries which have required surgery: _____

_____

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

_____

Date of your last medical physical_____

Any abnormal findings/concerns? _____

_____

List medications (prescriptions 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_____

Partner __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

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

_____

I authorize treatment by Licensed Acupuncturists at Seasons of Balance Family Acupuncture, LLC. All information on this form is correct.

Patient (or guardian) Signature: _____ Date: _____