


NAPERVILLE ACUPUNCTURE CENTER
1801 NORTH MILL SUITE G, NAPERVILLE, IL 60563
630-369-3237 WWW.NAPERACUCENTER@SBCGLOBAL.NET
HEALTH HISTORY QUESTIONNAIRE AND REGISTRATION

PATIENT INFORMATION	CONTACT INFORMATION
Date _____	Home phone _____
Name _____	Work phone _____
Address _____	Cell/Other phone _____
City, State, Zip _____	Email _____
Age _____ Date of Birth _____	Emergency Contact _____
Occupation _____	Name _____
Company name _____	Home phone _____
Primary physician _____	Work phone _____
How did you hear about us? _____	Cell phone/other _____

HEALTH CONCERNS	FINDING OUR CLINIC
<p>Please list your main health concerns</p> <p>1) _____</p> <p>2) _____</p> <p>3) _____</p> <p>4) _____</p> <p>5) _____</p>	<p>We are located on the North ~ West corner of Mill St. and Diehl Rd. Turn into Naperville Office Court, turn left before the mailboxes, Suite 1801 G.</p> 

MEDICAL HISTORY
<p>Please list ALL medications you are taking:</p> <p>List any serious illnesses, accidents or surgeries:</p> <p>Please list any supplements you are taking:</p>

MEDICAL HISTORY

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stomach Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Vein Condition |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Blood disorder |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Spleen Disease | |

MUSCULOSKELETAL

Pain, weakness, numbness in (indicate right or left):

- | | |
|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Arm | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Back |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Leg | <input type="checkbox"/> Other |

CARDIOVASCULAR

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Tachycardia |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other |

EYES/EARS/NOSE/THROAT

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Nose bleed |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Headaches/tension/
migraine/sinus/other |
| <input type="checkbox"/> Grinding teeth | |
| <input type="checkbox"/> Itchy Eyes | |

RESPIRATORY

- | |
|--|
| <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Tightness in Chest |
| <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cough, Dry |
| <input type="checkbox"/> Cough, Productive |

SKIN AND HAIR

- | |
|--|
| <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Hives |
| <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Itching |
| <input type="checkbox"/> Fungal Infections |
| <input type="checkbox"/> Hair Loss |

NEUROLOGICAL

- | |
|--|
| <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Depression |
| <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Easily Stressed |
| <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Difficulty Sleeping |

GENITO-URINARY

- | |
|---|
| <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Incomplete Urination |
| <input type="checkbox"/> Kidney Stone |
| <input type="checkbox"/> Pain with Urination |
| <input type="checkbox"/> Venereal Disease |

GASTROINTESTINAL

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Belching, gas or bloating | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Laxative use |
| <input type="checkbox"/> Burning Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Vomiting |
| | <input type="checkbox"/> Hemorrhoids |

MEN'S HEALTH

- | | |
|--|---|
| <input type="checkbox"/> Swollen Testes | <input type="checkbox"/> Coldness or numbness |
| <input type="checkbox"/> Testicular Pain | <input type="checkbox"/> Testicular cysts |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Enlarged Prostate |
| <input type="checkbox"/> Premature Ejaculation | |

WOMEN'S HEALTH

- | | |
|---|--|
| <input type="checkbox"/> Bleeding Between Periods | <input type="checkbox"/> Painful Period |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Vaginal Discharge |
| | <input type="checkbox"/> Menopausal Symptoms |

The information on this form is correct to the best of my knowledge.

Signature _____ Date _____