Hello and welcome to our practice,

We are very happy to welcome you to our Acupuncture and Holistic Health Practice. We want you to know that we appreciate the chance to take care of you and your family. Our Practice is focused on providing you with a holistic view to healing and educating patients.

During your first visit, Dr. Radloff-Seelman will go over a full medical history with you. Please bring with you any supplements and medications you are currently taking. (Please bring along all bottles/containers to the appointment as well)

We ask that you allot 2 hours for this first appointment as your full medical history will be discussed and an acupuncture treatment given. Follow-up treatments will last about 75 minutes. Our policy for new patients is that if you miss your first scheduled appointment, any future new patient appointments must be pre-paid.

If you are in need of ongoing treatment, a treatment plan will be discussed with you. You will have the chance to review the recommended treatment plan and ask any questions that you may have.

Enclosed you will find a health history form and questionnaire. Please fill them out entirely (4 pages in total) and bring them with you to your appointment. While our services are not typically covered by major health insurers, if you have a Flex Spending account with your insurance provider you are able to use that with us.

Thank you for choosing our Practice and we are looking forward to meeting you.

Sincerely,

Dr. Marcia Radloff - Seelman

Dr. Marcia Radloff-Seelman & Staff

Pristine Health LLC

621 E. Main St.

Watertown, WI 53094

Ph. 920-261-6999 Fx. 920-261-6966

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MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. **Please print and complete all information.**

Case No.	Medicare No.	Medicaid No.	Today's Date	Birth date	Male ☐ Female ☐
Last Name First Middle			Daytime phone		Home Phone
Address City State Zip			Marital Status		Occupation
Person to notify in emergency	Daytime Phone	Relationship			Last Physical Examination Date
By Doctor	Phone	Family or Referring Doctor			Phone No.
May I contact either of these Doctors for your past health records? Yes ☐ No ☐	What are your present medical symptoms?				

Family History	IF LIVING Age	HEALTH Good Fair Poor	IF DECEASED Death Age	Death Cause
Father				
Mother				
Brothers Sisters (Circle Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
Husband ☐ Wife ☐				
Sons Daughters (circle sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
6. M F				

Any blood relatives who have or have had any of the listed conditions

	✔ Yes	No	Relationship		✔ Yes	No	Relationship
Asthma				Hay Fever			
Arthritis				Insanity			
Allergies				Kidney Disease			
Anemia				Leukemia			
Alcoholism				Migraine			
Bleeding Tend.				Nervous Break'n			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumatic Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stomach Ulcers			
High Bl. Press.				Tuberculosis			
Heart Disease							

HABITS

Do You	✔ Yes	No	Daily Consumption:
Smoke	☐	☐	______ Pkgs.
Drink Coffee	☐	☐	______ Cups
Drink Alcohol	☐	☐	______ oz.
Drink Beer	☐	☐	______ oz.
Fall Asleep Easily	☐	☐	
Awaken Early	☐	☐	

MEDICATIONS

✔ If Taken	✔		✔		✔		✔
Antacids	☐	Blood Thinning Pills	☐	Iron or Poor Blood Med.	☐	Vitamins	☐
Antibiotics	☐	Cortisone	☐	Laxatives	☐	Water Pills	☐
Aspirin, Bufferin, Anacin	☐	Cough Medicine	☐	Phenobarbital	☐	Weight Reducing Pills	☐
Barbiturates	☐	Digitalis	☐	Shots	☐	Other (list) ______	
Birth Control Pills	☐	Dilantin	☐	Sleeping Pills	☐	______	
Blood Pressure Pills	☐	Hormones	☐	Thyroid Med.	☐	______	
		Insulin, Diabetic Pills	☐	Tranquilizers	☐	______	

Operations you have had: Year	Diseases you have had requiring hospitalization Year	Serious illness not requiring hospitalization Year

Drugs you are allergic to:

Describe any serious injuries or accidents you have had

WOMEN only:

	✔ Yes	No	
Are you still having regular monthly menstrual periods?	☐	☐	
Have you ever had bleeding between your periods?	☐	☐	When?
Do you have very heavy bleeding with your periods?	☐	☐	When?
Do you feel bloated and irritable before your period?	☐	☐	
Are you now on or have you ever taken the birth control pill?	☐	☐	When?
Have you ever had a miscarriage?	☐	☐	When?
Have you ever had a discharge from the nipple of your breast?	☐	☐	When?
Do you regularly have the cancer test of the cervix?	☐	☐	Date of last test

How many children born alive ______
How many stillbirths ______
How many premature births ______
Date of last menstrual period ______
How many miscarriages ______
How many cesarean operations ______
Any complications of pregnancy? (explain) ______

MEN only: Have you ever had:

	✔ Yes	No
Loss of sexual activity? For how long? ______	☐	☐
Treatment for genitals (private parts)?	☐	☐
Discharge from penis?	☐	☐
Hernia (rupture)?	☐	☐
Prostate trouble?	☐	☐

MEN and WOMEN:	✔ Yes	No
Do you frequently have severe headaches	☐	☐
(If yes, answer the following):		
Do they cause visual trouble?	☐	☐
Do they occur on one side of the head?	☐	☐
Do they awaken you at night?	☐	☐
Do they feel like a tight hat band?	☐	☐
Do they hurt most in the back of the head and neck?	☐	☐
Does aspirin relieve them?	☐	☐

Have you recently had pain in the stomach which:	✔ Yes	No
Occurs 1-2 hours after a meal?	☐	☐
Is brought on by eating fried foods, gassy foods?	☐	☐
Awakens you at night?	☐	☐
Is relieved by antacid medications?	☐	☐
Is relieved with milk or eating?	☐	☐
Occurs while eating or immediately after?	☐	☐
Is relieved by a bowel movement?	☐	☐
Causes loss of appetite?	☐	☐

	✔ Yes	No		✔ Yes	No
Have you ever fainted?	☐	☐	Have you ever had a convulsion?	☐	☐
Spells of dizziness?	☐	☐	Double vision?	☐	☐
Spells of weakness of arm or leg?	☐	☐	Pains in ear?	☐	☐
Ringing in ears?	☐	☐	Nosebleeds?	☐	☐

Do you frequently have:	✔ Yes	No		✔ Yes	No
Bleeding gums?	☐	☐	A sore tongue?	☐	☐
Trouble swallowing?	☐	☐	Nausea and vomiting?	☐	☐
Hoarseness?	☐	☐			

Have you ever had shortness of breath?	✔ Yes	No
Doing your usual work?	☐	☐
Climbing a flight of stairs?	☐	☐
Which awakens you at night?	☐	☐
Do you have a chronic cough?	☐	☐
Which causes you to cough?	☐	☐
Accompanied by wheezing?	☐	☐
Have you ever coughed blood?	☐	☐
Do you cough up much sputum?	☐	☐

Have you had pain or tightness in the chest which begins:	✔ Yes	No		✔ Yes	No
When exerting yourself?	☐	☐	Radiates down the arm?	☐	☐
When walking against a wind?	☐	☐	Disappears if you rest?	☐	☐
When walking up a hill?	☐	☐	Occurs only at rest?	☐	☐
After a heavy meal?	☐	☐	When walking fast?	☐	☐
When upset or excited?	☐	☐	When walking in cold weather?	☐	☐
Palpitations	☐	☐	If you have chest pain or tightness please explain		
Do you sleep on more than one pillow?	☐	☐			

Have you had?	✔ Yes	No	When or since when?
Burning when urinating?	☐	☐	
Loss of control of bladder?	☐	☐	
Blood in the urine?	☐	☐	
Dark colored urine?	☐	☐	
Trouble starting to urinate?	☐	☐	
Trouble holding the urine?	☐	☐	
To get up frequently at night?	☐	☐	
Passed a kidney stone?	☐	☐	

Have you recently had:	✔ Yes	No	When or since when?
Pains in calves of legs when walking?	☐	☐	
Cramps in legs at night?	☐	☐	
Pain in the big toe?	☐	☐	
Varicose veins?	☐	☐	
Phlebitis or inflamed leg veins?	☐	☐	
Swelling in the ankles	☐	☐	

If you have had a change in bowel habit recently answer the following:	✔ Yes	No	When or since when?
Crampy pain in abdomen?	☐	☐	
Alternating diarrhea and constipation?	☐	☐	
Pain during or after bowel movement?	☐	☐	
Mucous in the stool?	☐	☐	
Blood in the stool?	☐	☐	
Ribbon like stools?	☐	☐	
Black stools?	☐	☐	
Require use of strong laxatives or enemas?	☐	☐	
	☐	☐	

Describe briefly your present medical symptoms and anything else we should know about your health.

MEDICATIONS, HERBAL AND OTHER SUPPLEMENTS

PATIENTS NAME______________________________________ DATE______________

Are you presently taking any of the following medications?

Analgesics (Aspirin, Ibuprofen, Naproxen Sodium)	dosage________	frequency______
CardiovascularAgents(Digoxin,Lanoxin,Captopril)	dosage________	frequency______
Laxatives	dosage________	frequency_____
Antacids	dosage________	frequency _____
Sedative, Antianxiety, Antipsychotic drugs	dosage________	frequency_____
Anti Inflammatories (Prednisone, NSAIDS, Corticosteroids)	dosage________	frequency_____
Respiratory Agents	dosage________	frequency_____
Diuretics	dosage________	frequency_____
Antibiotics	dosage________	frequency_____
Elixirs containing sorbitol (Acetaminophen)	dosage________	frequency_____
Insulin or Diabetic pills	dosage________	frequency_____
Sleeping Pills	dosage________	frequency_____
Thyroid Medication	dosage________	frequency_____
Blood-thinning Pills	dosage________	frequency_____
Seizure medication	dosage________	frequency_____
Weight Reducing Pills	dosage________	frequency_____
Birth Control (Pills, Patch, Ring, Injection)	dosage________	frequency_____
Hormones	dosage________	frequency_____
Blood Pressure Pills	dosage________	frequency_____
Statin Drugs	dosage________	frequency_____

List any other over-the-counter medications you currently use

____

List any herbal or natural supplements, vitamins or minerals you are taking

____

____

Please Bring In Your Supplements and Medications to Your First Visit.

Are you allergic to any medications, natural supplements, or over-the-counter medications?
Please name them____

1. Overall, do you generally feel more warm or cold?_______________
2. Do you ever have hot flashes? Yes or No
3. Do you perspire easily? Yes or No
4. Do you perspire only with exercise or exertion or do you sweat while sitting still, or after eating?_______________
5. Do you frequently get headaches? Yes or No
6. If yes, describe your headaches, location and severity on a scale of 1 to 10_______________
7. Do you have any joint or other body aches?_______________
8. Do you ever have shortness of breath? Yes or No
9. Do you have chest pains? Yes or No
10. Do you have heart palpitations? Yes or No
11. Do you have acid reflux, heartburn, indigestion, bloating or gas? Circle any that apply to you.
12. How is your appetite?_______________
13. How much water do you drink each day?_______________
14. Do you feel excessively thirsty?_______________
15. How much caffeine do you drink daily?_______________
16. Do you drink alcoholic beverages? Yes or No How much daily?_______________
17. Do you have any difficulty with urination, such as hesitancy, burning, itching, difficulty stating or stopping the flow, dribbling, or loss of bladder control when coughing, laughing, or sneezing? Circle any that apply to you. How many times per day do you urinate?__________ How many times per night?__________
18. How many times per day do you have a bowel movement?________ Is it difficult to pass? Circle what applies to you......I need to sit and read......It takes me a few minutes...I'm done in 15 seconds. Do you often have diarrhea or constipation? Yes or No
19. Describe your diet_______________
20. Do you have any floaters (black spots) in your vision? Yes or No If yes, do they move around or stay in one place?_______________
21. Any other vision problems such as macular degeneration or cataracts? Yes or No
22. Do you have any hearing loss or ringing in your ears?_______________
23. How many hours do you sleep each night?_______________
24. Do you feel rested when you wake up? Yes or No
25. Do you have any night sweats? Yes or No?
26. Do you have any reproductive issues you woul like to discuss such as infertility, PMS, menopausal symptoms, menstrual cramps, low libido, erectile dysfunction? Yes or No
27. How do you rate your overall health?_______________
28. How did you hear about our clinic?_______________