Janine Maere, MD 209 S. Prospect Dr.

309-336-0190 Office Suite 1

Bloomington, IL

61704

ACUPUNCTURE CONSULTATION

1. Please complete the enclosed medical history forms, and bring them with you to your first appointment.

2. We require a minimum 24 hour notice of cancellation if you are unable to keep your appointment.

IMPORTANT: Please complete this document as thoroughly as possible. All information is strictly confidential.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (last, first, MI):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     State:\_\_\_\_\_\_\_     Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Sex:  Female/ Male

Marital Status (circle one): Married/ Single/ Divorced/ Widowed

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Health Care Physician/MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    If referred, please give the name of who referred you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had acupuncture before: Y/N

If yes, from whom:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated by a Homeopath before? Y/N

If yes, from whom:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker or other implantable device: Yes No

MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do these conditions impair your daily activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAST MEDICAL HISTORY

Check any that you have had in the past:

❏ Diabetes ❏ Heart Disease ❏ Asthma ❏ Jaundice ❏ Syphilis

❏ Meningitis ❏ Epilepsy ❏ Paralysis ❏ Other Lung Illness

❏ Allergies ❏ CVA (stroke) ❏ Pneumonia ❏ Gonorrhea ❏ Measles

❏ HIV ❏ High Fever ❏ Cancer ❏ Other Liver Illness

❏ Glaucoma ❏ Vein Condition ❏ Tuberculosis ❏ Mumps ❏ Chicken Pox

❏ Polio ❏ Hepatitis ❏ Migraines ❏ Other Heart Illness

❏ Rheumatic Fever ❏ Thyroid Disorder ❏ Emphysema

❏ Bleeding Tendency ❏ Nervous Disorder ❏ Mononucleosis

❏ Multiple Sclerosis ❏ High Blood Pressure ❏ Other Kidney Illness

❏ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any major injuries you may have had in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What vaccinations have you had: \_\_\_\_\_ Tetanus- Date:\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Shingles- Date:\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Pneumonia- Date:\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Meningitis- Date:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Gardisil- Dates:\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Chicken Pox -Date:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Hepatitis B- Dates:\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Hepatitis A- Dates:\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_MMR- Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Influenza – Date:\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any adverse reactions to them? Please list information below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgical History

Please list any major surgeries you may have had in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are over 50, have you had a colonoscopy? Y / N If so, when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications and Supplements

Please list all prescribed and over the counter medications, supplements, and vitamins you  are currently taking routinely. Indicate the dosage and reason for taking, as well. Write on the back of the sheets if needed.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_ purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_   purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_    purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_  purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_   purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If additional medications, please list on the back of this form.

Allergies

Are you allergic to any medications : Y / N

Are you allergic to any supplements/herbs: Y / N

Are you allergic to any food: Y / N

Are you allergic anything in the environment: Y / N

Are you allergic to anything else: Y / N

If so, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History

Relative Alive Health Conditions/Cause of Death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother Y / N

Father Y / N

MGF Y / N

MGM Y / N

PGF Y / N

PGM Y / N

Sister Y / N

Brother Y / N

Other Y / N

Diet & Lifestyle

Do you drink caffeine:  Y / N     how much: \_\_\_\_\_\_\_\_\_  coffee / tea / soda/ energy drinks

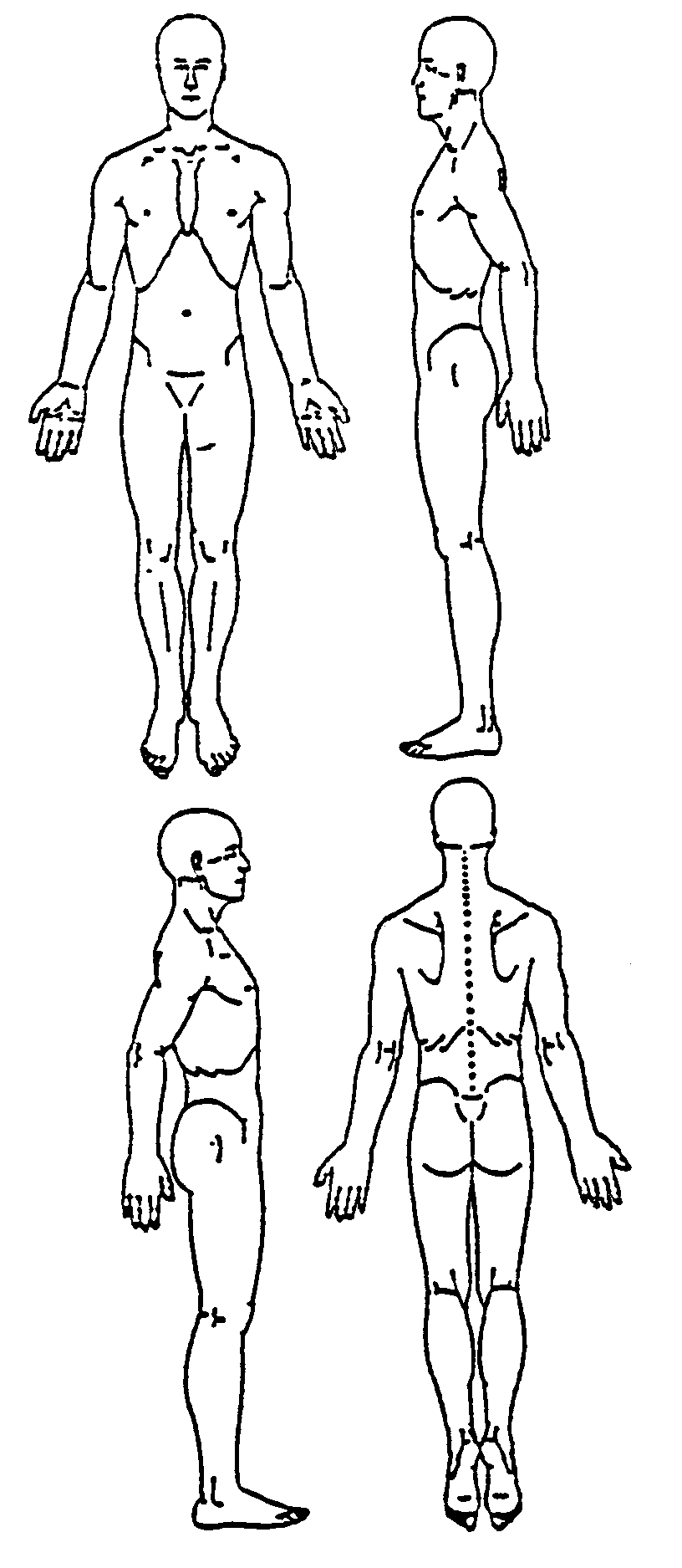
Do you drink alcohol:  Y / N       how much: \_\_\_\_\_\_\_\_\_

Do you smoke: Y / N      how much: \_\_\_\_\_\_\_\_\_

Do you chew tobacco: Y / N how much: \_\_\_\_\_\_\_\_\_\_

Do you do recreational drugs: Y / N which ones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Profile Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars)



Is the pain:

❏ Sharp ❏ Cramping ❏ Fixed ❏ Burning ❏ Dull

❏ Aching ❏ Moving ❏ Other:

Do the following improve the pain?

❏ Pressure ❏ Exercise ❏ Cold ❏ Heat ❏ Other:

Do the following worsen the pain?

❏ Pressure ❏ Cold ❏ Heat ❏ Other:

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ’s function):

OVERALL TEMPERATURE (Kidney Function)

❏ Sweaty feet ❏ Hot body temperature (sensation) ❏ Cold body temperature (sensation)

❏ Afternoon flushes ❏ Hot flashes any time of the day ❏ Heat in the hands, feet, and chest

❏ Night sweats ❏ Thirsty ❏ Perspire easily ❏ Lack of perspiration

❏ Take water to bed

OVERALL ENERGY (Lung, Kidney function)

❏ Shortness of breath ❏ Low energy ❏ Difficulty keeping eyes open in the daytime

❏ Feel worse after exercise ❏ General weakness ❏ Easily catch colds

OVERALL BLOOD (Liver, Spleen, Heart function)

❏ Dizziness ❏ See floating black spots

HEART FUNCTION

❏ Palpitations ❏ Anxiety ❏ Drink coffee (# of cups per week:\_\_\_\_\_\_\_)

❏ Sores on the tip of the tongue ❏ Restlessness ❏ Mental confusion

❏ Chest pain traveling to shoulder ❏ Frequent dreams ❏ Wake unrefreshed

LUNG FUNCTION

❏ Nasal Discharge (Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ❏ Allergies (To what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

❏ Headache (Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ❏ Smoke cigarettes (# of cigarettes a day: \_\_\_)

❏ Cough ❏ Nose Bleeds ❏ Sinus Congestion ❏ Alternating fever and chills

❏ Dry Mouth ❏ Stiff neck ❏ Stiff shoulders ❏ Melancholy

❏ Sadness ❏ Dry throat ❏ Dry nose ❏ Dry skin

❏ Sore throat ❏ Difficulty breathing ❏ Sneezing ❏ Achy feeling

SPLEEN FUNCTION

❏ Low appetite ❏ Abrupt weight gain ❏ Abrupt weight loss ❏ Abdominal bloating

❏ Prolapsed organs (previously diagnosed, which organ? \_\_\_\_\_\_\_\_\_\_\_\_)

❏ Abdominal gas ❏ Gurgling noise in the stomach ❏ Fatigue after eating

❏ Easily bruised ❏ Hemorrhoids ❏ Pensive ❏ Worry

❏ Over-thinking

SPLEEN, STOMACH, LARGE INTESTINE, SMALL INTESTINE FUNCTION

❏ Loose ❏ Constipated ❏ Incomplete ❏ Diarrhea

❏ Blood in stools ❏ Mucous in stools ❏ Undigested food in stools

DAMPNESS TRAPPED IN THE BODY

❏ Mental heaviness ❏ Mental sluggishness ❏ Mental fogginess ❏ Snoring

❏ General sensation of heaviness in the body ❏ Swollen hands ❏ Swollen feet

❏ Swollen joints ❏ Chest congestion ❏ Nausea

STOMACH FUNCTION

❏ Large appetite ❏ Bad breath ❏ Mouth (canker) sores

❏ Heartburn ❏ Acid regurgitation ❏ Burning sensation after eating

❏ Ulcer (diagnosed) ❏ Belching ❏ Bleeding, swollen or painful gums

❏ Hiccups ❏ Stomach pain ❏ Vomiting

LIVER, GALLBLADDER FUNCTION

❏ Alternating diarrhea and constipation ❏ Headache at the top of the head

❏ Tight sensation in the chest ❏ Bitter taste in the mouth

❏ High-pitched ringing in the ears ❏ Gall stones (history or current)

❏ Frustration ❏ Depression ❏ Irritability ❏ Skin rashes

❏ Chest pain ❏ Anger easily ❏ Tingling sensation ❏ Numbness

❏ Muscle spasms ❏ Muscle twitching ❏ Muscle cramping ❏ Seizures

❏ Convulsions ❏ Lump in the throat ❏ Neck tension ❏ Drink alcohol

❏ Shoulder tension ❏ Limited Range-of-Motion, neck

❏ Limited Range-of-Motion, shoulder

❏ Sexually transmitted disease (Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )

❏ Recreational drugs (Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , How much per week? \_\_\_\_\_\_\_\_ )

❏ Frequently unable to adapt to stress (What causes the stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )

EYES (Liver function)

❏ Itchy ❏ Bloodshot ❏ Hot ❏ Dry

❏ Watery ❏ Gritty ❏ Blurry vision ❏ Decreased night vision

❏ Near-sighted ❏ Far-sighted

KIDNEY, URINARY BLADDER FUNCTION

❏ Frequent cavities ❏ Sore knees ❏ Weak knees

❏ Cold sensation in the knees ❏ Low back pain ❏ Memory problems

❏ Excessive hair loss ❏ Kidney stones ❏ Low-pitched ringing the ears

❏ Bladder infections ❏ Easily broken bones ❏ Lack of bladder control

❏ Fear ❏ Easily startled ❏ Wake during the night twice to urinate

URINATION

❏ Normal color ❏ Dark yellow ❏ Clear ❏ Reddish

❏ Cloudy ❏ Scanty ❏ Profuse ❏ Strong color

❏ Burning ❏ Urgent ❏ Frequent ❏ Painful

❏ Discharge ❏ Difficult

LIBIDO

❏ Normal ❏ High ❏ Low

WOMEN ONLY

Regular menstrual cycle? ❏ Y ❏ N Number of children: \_\_\_\_\_\_\_ Age of first menstruation: \_\_\_\_\_\_\_\_ Average number of days of flow: \_\_\_\_\_\_\_\_\_\_\_ Vaginal discharge? ❏ Y ❏ N Pregnant? ❏ Y ❏ N Number of pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of menopause (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average number of days of entire cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bleeding between periods? ❏ Y ❏ N

Do you experience any of the following pre-menstrual syndromes?

❏ Nausea ❏ Food cravings ❏ Depression ❏ Vomiting

❏ Headaches ❏ Irritability ❏ Water retention ❏ Migraines

❏ Anxiety ❏ Breast swelling ❏ Breast tenderness

❏ Sharp pain, Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❏ Dull pain, Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Please fill out the following menstrual chart: | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| Color (normal, bright red, pale, rust, brown, |  |  |  |  |  |  |  |
| dark, purple, other) |  |  |  |  |  |  |  |
| Amount of Flow (normal, heavy, light) |  |  |  |  |  |  |  |
| Pain/Cramps (location, dull, sharp, other) |  |  |  |  |  |  |  |
| Clots (large, small, black, red, purple, other) |  |  |  |  |  |  |  |
| Vomiting (check if yes) |  |  |  |  |  |  |  |
| Nausea (check if yes) |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

MEN ONLY

❏ Swollen testes ❏ Testicular pain ❏ Impotence

❏ Feeling of coldness or numbness in external genitalia

❏ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_