NATURAL HEALTH CENTER
Dr. William T. Eickhoff D.C.
1033 Clifton Avenue 973-470-0687 Clifton, N.J. 07013

ACUPUNCTURE PERSONAL HISTORY

Name:_____ Date:_____

Address:_____ Social Security Number:_____

City:_____ State:_____ Zip Code:_____ Sex M F

Home Phone( ) _____ Business Phone( )_____

Cell Phone ( )_____Birthday _____Age_____

Email address_____Emergency contact_____

Occupation:_____Business/Employer:_____

Referred by:_____

Marital status: M S W D Name of Spouse _____
Are you insured: Y N Primary Company name _____
Secondary Company name _____

Have you had acupuncture before? Y N

Check any of the following that pertain to you: __Hepatitis __HIV __High Blood Pressure
__ Surgical Implants __ Seizures __Pacemaker __Blood Thinners __Pregnancy

Please list your top three health concerns

	How Long
1. _____	_____
2. _____	_____
3. _____	_____

1. Chief complaint (reason you are here): _____
_____

2. How did your problem begin? _____

↑ Auto accident ↑Work related accident ↑Other type of accident

↑ Gradual Sudden Cumulative Trauma Repetitive Stress No specific reason

3. How long have you had this problem? _____

4. How would you describe your pain?
Dull Sharp Throbbing Burning Deep Ache Tingling Stabbing

Cramping Spasm Tightness Numb Stiff Radiating

5. How would you rate the intensity of your pain right now? (Circle a number)

0 1 2 3 4 5 6 7 8 9 10
(minimal) (mild) (moderate) (severe) (unbearable)

6. How frequent is the problem?
Constant daily _____ times per day week month year

7. What percent of the day is the pain present during your waking hours? (circle one)

↑ 0%↑10%↑20%↑30%↑40%↑50%↑60%↑70%↑80%↑90%↑100%

8. Since your problem began, is your pain:
↑ Getting better ↑Getting worse ↑Staying the same

9. What makes your problem better?
Sitting Standing Lying Heat Movement No movement Ice Topical analgesic
Medication Over the counter medication Stretching Exercise Other-
↑

10. What makes your problem worse? _____
_____

↑11. Is your problem affecting your ability to work or do other routine daily activities? Y N explain
_____

12. What prescriptions or over-the-counter medications are you taking?

Medication	Reason for Taking	How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

13A. Were you previously treated for this condition? ↑Yes ↑No *If yes, please describe by whom*↑
MD/DO Physical therapist ↑Acupuncturist (for Chiropractor see number 14)

13B. First Doctor's or Practitioner's Name _____
Address_____
Diagnosis - what did they say was/is wrong _____
Treatment/medication provided _____
Date of first treatment _____last treatment _____ Did/does it help? Y N

Second Doctor's or Practitioner's Name _____
Address_____
Diagnosis - what did they say was/is wrong _____
Treatment/medication provided _____

Date of first treatment _____last treatment _____ Did/does it help? Y N

14. Have you been treated by a Chiropractor for this or another problem? Yes No

Chiropractor's name and address_____

Reason for treatment_____

Date of first treatment_____ date of last treatment_____

Number of treatments ____ How often did you see the Doctor_____Did it help? Y N

15. Please list any Doctor's you have seen in the last year or are seeing now_____
_____

16. Have you been treated for any health conditions in the last year? ___Yes ___No If Yes, explain:
_____

17. List any major illnesses you have had: _____

18. Do your have any other health problems? Yes No _____

19. Have you had any car accidents YES NO _____
or other accidents or falls: YES NO _____

20. Any ER or hospitalization_____

21. Any surgery: Appendectomy Tonsillectomy Gall Bladder Hernia Spinal
Other surgery or Broken Bones _____

22. Please list any x-rays, MRIs, CT scans, bone density, bone scans that you have had:

Area of body	Type of Test	Where was it done?	When	Results/do you have the report

23. What is your physical activity at work?
↑ Mostly sitting ↑Light manual ↑Moderate manual ↑Heavy manual

24. Do you exercise?
↑ No regular exercise ↑1-2 times/week ↑3-4 times/week ↑5-7 times/week
↑ Cardiovascular ↑Stretching ↑Weight Machine ↑Free Weights
↑ Sports_____

25. What is your general stress level? ↑No stress ↑Minimal stress ↑Moderate Stress ↑Greatly stressed

26. Please list the vitamins, herbs or nutritional supplements you take

Supplement	Reason	How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

27. ***ON THE NEXT PAGE PLEASE –***

MARK ANY OF THE CONDITIONS OR PROBLEMS THAT YOU HAVE **NOW WITH AN "N"**
MARK ANY OF THE CONDITIONS YOU HAD **IN THE PAST WITH A "P"**

MARK ANY OF THE CONDITIONS OR PROBLEMS THAT YOU HAVE **NOW** WITH AN **"N"**
MARK ANY OF THE CONDITIONS YOU HAD IN THE **PAST** WITH A **"P"**

Musculoskeletal Pain, Numb or Stiff	Gastrointestinal	__Earaches
__Headache, Migraine	__Diabetes	__Hearing Aides
__Jaw pain, jaw clicking	__GERD, Acid Reflux, Heartburn	Nose, Throat, Mouth
__Neck pain, stiffness	__Colitis	__Allergies
__Neck Disk Degeneration	__Colon Cancer	__Sinus/Nasal infection or congestion
__Neck Disk Herniation or Bulge	__Diverticulitis	__Tonsillitis
__Shoulder(s)	__Weight loss/gain	__Frequent Colds
__Arms(s)	__Constipation, laxative use	__Frequent Sore Throat
__Elbow(s)	__Diarrhea	__Difficulty Swallowing
__Forearm(s)	__Bloody Stool	__Excessive Phlegm
__Wrist(s), Carpal Tunnel	__Stomach pain, cramps	__Loss of Voice
__Hand(s)	__Gall Bladder pain	__Mouth or Tongue Ulcers
__Finger(s)	__Digestion trouble, Indigestion	__Dry Mouth
__Upper back	__Nausea	__Gum Problems
__Between Shoulder Blades	__Vomiting	__Dry Nose
__Midback (below shoulder blades)	__Gas	__Nosebleeds
__Low back	__Hiccups	Skin
__LB Disk Degeneration	__Bloating	__Hives, Rashes, Itching
__LB Disk Herniation or Bulge	__Poor appetite	__Eczema or Psoriasis
__Sciatica	__Thirsty often	__Dry Skin
__Buttock(s)	__Excessive hunger	__Excessive Sweating
__Hip(s)	Cardiovascular	__Night Sweating
__Upper Leg(s)	__Heart Attack or Surgery	__Easily Bruised
__Knee(s)	__Chest Pain, Tightness	__Changes in Moles or Lumps
__Lower Leg(s)	__High/Low Blood Pressure	Women
__Ankle(s)	__Palpitations	__Pregnant or may be
__Feet	__Irregular or Rapid Heartbeat	__# of Pregnancies
__Arthritis	__Pacemaker	__Miscarriages
__Bursitis	__Poor Circulation	__Abortions
__Swollen Joints	__Varicose Veins or Phlebitis	__Menstrual Irregularity
__Walking Problems	__Swollen Ankles	__Menstrual Cramps
__Weak Muscles	__Short Breath	__Menstrual Backache
__Limited Range of Motion	__Anemia	__Excessive Blood Flow or Blood Clots
Nervous System	Urinary	__Menopause, Pre, Post
__Convulsions, Seizures, Epilepsy	__Bladder Cancer	__Hormone Replacement Therapy
__Paralysis	__Pain on Urination	__Uterine Fibroids
__Tremors	__Frequent Urination	__Endometriosis
__Sweats	__Unable to Hold Urine	__Hysterectomy/other surgery
__Numbness, tingling	__Incomplete Urination	__Abnormal Pap Smear
__Stroke	__Wake to Urinate	__Vaginal Pain, Infection or Itching
__Forgetfulness	__Kidney Infection / Stone	__Breast Pain, Lumps or Cysts
__Confusion	Respiratory	__Mammography
__Nervousness	__Smoke Cigarettes	Men
__Fainting	__Lung Cancer	__Swollen Prostate
__Dizziness or Vertigo	__Asthma, Wheezing	__Prostatic Cancer
__Poor Co-ordination	__Emphysema	__Testicular Lumps or Cancer
__Cold/tingling arms, hands, fingers	__Pneumonia	__ Pain or itching genitalia
__Cold/tingling legs, feet, toes	__Tuberculosis	__Impotence
General	__Difficulty Breathing	__Premature Ejaculation
__Insomnia	__Persistent Cough	__Nocturnal Emission
__Dreams, Nightmares	__Wet or Dry Cough	Sexual

__Fatigue	__Coughing up Blood or Phlegm	__Increased Libido
__Chills	Eyes & Ears	__Decreased Libido
__Fever	__Glasses or contacts	__Sexually Transmitted Disease
__Strongly Like Cold Drinks	__Blurred or Double Vision	Mental, Emotional
__Strongly Like Hot Drinks	__Poor night vision	__Depression, Antidepressant use
__Cancer	__Spots or Floaters	__Difficulty Focusing
__Alcoholism, Drug Use	__Glaucoma	__Mood Swings

28. Social and Occupational History

Level of education _____

Job description_____

Work schedule_____

Recreational activities_____
Amount of exercise: _____ Alcohol use: _____
Tobacco use: _____ Drug use: _____
Coffee use: _____

Any household pets or other animals you or family members are in close contact with:

_____

29. Family History

Relationship	Health Problem(s)- such as heart disease, diabetes, arthritis, osteoporosis, cancer etc.
Father	
Mother	
Brother	
Sister	

30. Is there anything else you wish to tell the Doctor?_____
_____
_____
_____
_____

31. What can we do to make you happier? _____
_____
_____
_____

Please read and sign the following certification:

I certify that the information I have given on the preceding pages is true and complete. I have not withheld any information relative to my health or any condition, problem or symptom. I hereby authorize Eickhoff Chiropractic and Nutrition Family Wellness Center, its Doctors and Staff, to provide me with care in accordance with this State's statutes.

_____ _____
Patient's (Parent/Guardian) Signature Date

THANK-YOU!
Dr. Eickhoff