

kindo

integrated health center

acupuncture • herbal formulas • thermal imaging

890 elm grove rd. • elm grove, wi 53122 • Tel (262) 827-4000

Fax (262) 827-1503

禧

Health Survey Online

Name: _____ Date: _____

Date of Birth: _____ Place of Birth: _____

If under 18, parent's name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ (W) _____ (C) _____

E-mail Address: _____

Relationship Status:

Single and living alone

Single and living with partner

Married. Spouse's name: _____

Do you have children?

Please give names and ages: _____

Occupation: _____

Referred By: _____

Primary Complaint:

Please include, briefly, location of complain, time of onset, cause (if known), factors that aggravate symptoms, and any other pertinent information.

Secondary Complaints:

Appetite and Taste

- Has your appetite altered recently?
- Do you have a poor appetite?
- Do you have poor digestion?
- Do you have epigastric (stomach) distention?
- Do you have abdominal (large intestine) distention?
- Are you experiencing belching?
- Are you passing gas?

What percentage of your diet is the following:

_____ Animal protein _____ Vegetables _____ Carbohydrates (bread, rice, pasta)
_____ Fruit _____ Sweets _____ Snacks

List any suspected or know food allergies:

Thirst and Dryness

- Do you have dry eyes?
 - Do you have dry nose or lips?
 - Do you have dry skin or dry hair?
- How many glasses of water or fluids do you drink daily? _____

Stools and Urine

Are your stools?

- Normal? (daily with same shape and size)
- Unusually hard?
- Unusually loose?
- Erratic in form (sometimes hard, sometimes loose)?
- Do you have bowel movements less than 5 times per week (constipation)?
- Is there any blood or pus in your stool?
- Do you have hemorrhoids?

Is your urine?

- Unusually scanty and dark?
- Unusually profuse and clear?
- Do you wake more than once at night to urinate?
- Do you experience any dribbling of urine?
- Do you have urgency to urinate?
- Do you experience burning urination?

Sleep

- Do you suffer from insomnia?
- Do you have restless sleep?
- Do you have uncomfortable dreams?

Emotions

Do you experience: ___Anger ___Worry ___Depression

 ___Fear ___Sadness ___Anxiety

___Do you experience mood swings?

___Are they related to eating and not eating?

___Do you take mood regulating prescription medication?

Structure

___Do you suffer from chronic or occasional backache or neck ache?

___Do you suffer from chronic or occasional joint pain?

___Do any muscles ache or cramp?

Accidents

Please list all major accidents, including fractures, deep cuts, serious sprains, etc. Please indicate all head injuries. Include dates or age:

Surgery History

Describe reason, age, and any consequential outcome.

Have you ever had a blood transfusion? _____ What year? _____

Exercise

What do you do for exercise? How often?

Disease History

Do your parents have any unusual health problems?

If they died, state cause of death and age of death.

Father:

Mother:

During your mother's pregnancy with you, did she:

___Drink alcohol ___Suffer serious illness ___Take medications

___Smoke cigarettes ___Suffer emotionally or physically

Please check (✓) if you have or have had any of the following

Now	Past		Now	Past	
___	___	Anemia	___	___	Head injury
___	___	Arthritis	___	___	Headaches
___	___	Asthma	___	___	Heart murmur
___	___	Bruising	___	___	Heart palpitations
___	___	Cancer	___	___	Hepatitis: Type ___
___	___	Candida	___	___	Herpes
___	___	Cholesterol, high	___	___	Hypertension
___	___	Chronic fatigue	___	___	Hypotension
___	___	Constipation	___	___	Kidney stones
___	___	Depression	___	___	Low sex drive
___	___	Diabetes	___	___	Mental illness
___	___	Diarrhea	___	___	Mononucleosis
___	___	Digestive problems	___	___	Nose bleeds
___	___	Dizziness, vertigo	___	___	Numbness, Neuropathy
___	___	Edema	___	___	Prostate problems
___	___	Epilepsy	___	___	Sciatic pain
___	___	Food allergies	___	___	Skin problems
___	___	Frequent colds	___	___	TMJ
___	___	Frequent gas	___	___	Ulcers
___	___	Gallstones	___	___	Venereal disease
___	___	Hayfever allergies	___	___	Parasites (type & date):

Any other serious illness, injury or complaint? If so, name:

Drug History – Please indicate current or previous use of the following:

Now	Past		Years usage
___	___	Anti-depressants, mood modifiers	_____
___	___	Antibiotics	_____
___	___	Antacids (Prilosec, Tagament, etc.)	_____
___	___	Asthma medications	_____
___	___	Birth control pills	_____
___	___	Hormone Replacement Therapy	_____
___	___	Pain medication (Prescription)	_____
___	___	Steroids (Prednisone, etc.)	_____
___	___	Thyroid medication	_____
___	___	Alcohol (in excess)	_____
___	___	Cigarettes	_____
___	___	Amphetamines	_____
___	___	Cocaine	_____
___	___	Heroin	_____
___	___	Marijuana	_____

Women Only

Do you have a history of:

- Amenorrhea (long time spans without a period)
- Breast implants. Were they removed? _____
- Chronic vaginal or yeast infections?
- DES baby
- Endometriosis
- Hysterectomy. What year? _____
- Infertility
- Irregular periods
- Menstrual cramps
- Miscarriage
- Ovarian cyst (single)
- Polycystic ovaries
- Pelvic Inflammatory Disease (PID)
- Uterine fibroids

Birth control method (past or present); number of years usage:

Menstrual history

- Are you currently pregnant?
- Are you presently suffering from a menopausal disorder?
- Have you completed menopause?

If you are still having your periods:

- Is your period regular?
- How many days between your periods?
- How many days does your period last?
- Are your periods painful?
- Is your ovulation painful?
- Do you bleed excessively? Too little?
- Do you discharge clots?
- Do you get headaches during menstruation or ovulation?
- Do you suffer from premenstrual syndrome (PMS)? If yes, please indicate:
 - Irritability Breast distention
 - Headache Water retention

How many days before your period do the PMS symptoms begin? _____

Pregnancy History

How many times have you been pregnant? _____

Do you have difficulty getting pregnant? _____

Have you had any abortions? How many? _____

Have you had any miscarriages? How many? _____

Have you had an ectopic pregnancy? _____

Did you have difficulty following childbirth? _____