

ABUNDANCE ACUPUNCTURE, INC.
W1185 McCrae Road
Fall River, WI 53932
(920) 484-5000

Health Survey

Purpose: review your personal state of health

To receive a **Free** initial consultation (\$160.00 value) please call our office at (920) 484-5000 and set up an appointment, then fill out the following as completely as possible and give this sheet to the receptionist before your appointment.

Name _____ Phone Number _____ Date _____

E-mail Address _____

Occupation _____ # hours per week currently working _____
 Retired (write in previous occupation above) working part time

Spouses Occupation _____ # hours per week currently working _____
 Retired (write in previous occupation above) working part time

1. Check off any of the following symptoms you have experienced in the past 3 months.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ankle or Foot Pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fatigue/Tired | <input type="checkbox"/> Elbow, Wrist, or Hand Pain | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Digestive Disturbances |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Pain Anywhere in the Body | <input type="checkbox"/> PMS | <input type="checkbox"/> acid reflux |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck or Shoulder Tension | <input type="checkbox"/> Menstrual Issues | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Allergies or Sinus Problems | <input type="checkbox"/> Menopausal Issues | <input type="checkbox"/> constipation |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Weight Trouble |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other _____ |

Which of the above bothers you the most? _____

How long have you been bothered by this condition? _____

Describe how it feels or affects you when it is at its worst? _____

2. Do these symptoms keep you from healthy activities?

- Keep you from exercising?
- Interfere with daily activities or household duties?
- Interfere with falling asleep?
- Interrupt your sleep during the night?
- Do they drain your energy and make you feel tired?

Exercise, activities, and proper sleep are critical to maintaining one's health, happiness, and vitality.

3. Are you currently taking Prescription Drugs or over the counter medications?

of medications 1 2 3 4 or more medications

How long have you taken these medications?

Will you continue to take these medications forever?
Is there any way that you could be healthier and not need to take these medications?

If you checked any of the above items your body's ability to communicate and heal is not working properly and your organs are probably not functioning as well as they could. ACUPUNCTURE AND HERBAL MEDICINE can help you because they gently and naturally restore the body's own healing capacity.

Have you reviewed our 14 Day Initial Diagnostic Plan (located on the FAQ page of our website)? yes no
 This plan sounds right for me. I would like to discuss the plan with an acupuncturist.

The best time for my appointment would be:

- Mornings Afternoons Early Evenings Mon. Tue. Wed. Thur. Fri.