wellness minneapolis

a fresh approach to health care

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Acupuncture Health History

Thank you for taking the time to fill out this health history questionnaire. The information provided allows your practitioner to create the most effective and appropriate treatment possible. You may skip any questions you do not feel comfortable answering. All information you share is confidential.

PATIENT INFORMATION

Name:

DOB:
Age:

Email Address:

Sign up for emails from your acupuncturist? ☐ Yes ☐ No

Parent or guardian (if under 18);

Emergency Contact:

Relationship to you:

HEALTH HISTORY & GOALS

What is your PRIMARY (#1) reason for being here?

How long have you had this condition?

On a scale from 1 to 10, please rate the severity of your discomfort:

What time of day do you usually feel this? During the day At night Random

What makes it feel better? Worse?

Have you seen a medical provider about this condition? ☐ Yes ☐ No
If yes, what was your diagnosis?

Please list any medications you are taking for this condition:

HEALTH HISTORY & GOALS CONTINUED

What is your SECONDARY (#2) reason for being here?

How long have you had this condition?

On a scale from 1 to 10, please rate the severity of your discomfort:

What time of day do you usually feel this? During the day At night Random

What makes it feel better? Worse?

Have you seen a medical provider about this condition? ☐ Yes ☐ No
If yes, what was your diagnosis?

Please list any medications you are taking for this condition:

DIET & EATING HABITS

Check any that apply:

Diet:

☐ Omnivore	☐ Salt restriction	☐ Fat restriction
☐ Vegetarian	☐ Carbohydrate restriction	☐ Count calories
☐ Vegan	☐ Poor balance	☐ Sleep problems

Eating Habits

☐ Skip breakfast	☐ One meal/ day	☐ Eat on the run
☐ Binge	☐ Two meals/ day	☐ Eat after 8pm
☐ Graze (small frequent meals)	☐ Eat constantly	☐ Emotional eating

FAMILY MEDICAL HISTORY

Check any that apply:

☐ Arthritis	☐ Stroke	☐ Infertility
☐ Depression/ Mental Illness	☐ Cancer	☐ Heart Attack
☐ Diabetes	☐ Other _____	

PERSONAL HEALTH HISTORY AND SYMPTOMS

Check any that apply:

- ☐ AIDS/ HIV
- ☐ Hepatitis
- ☐ Thyroid function
- ☐ Autoimmune disorder
- ☐ Stroke
- ☐ Anxiety/ Depression/ SAD
- ☐ Poor memory
- ☐ Frequent colds
- ☐ Chills/ Cold extremities
- ☐ Inappropriate Sweating
- ☐ Other

_____

- ☐ Pacemaker
- ☐ Heart attack/ CHF
- ☐ Bleeding/ bruising easily
- ☐ Cigarette Smoking/Emphysema
- ☐ Measles / Mumps
- ☐ Inability to focus/ADD/ADHD
- ☐ Emotional imbalances
- ☐ Changes in appetite
- ☐ Muscle cramp/spasm/twitches
- ☐ Sleep problems/ fatigue

- ☐ Bleeding disorder
- ☐ Alcoholism
- ☐ Seizures/ Epilepsy
- ☐ Appendicitis
- ☐ Eating disorder
- ☐ Numbness
- ☐ Anemia
- ☐ Body heaviness
- ☐ Herpes
- ☐ Poor balance

Do you experience any of the following symptoms EVERYDAY?

- ☐ Headaches
- ☐ Bleeding
- ☐ Insomnia
- ☐ Dizziness
- ☐ Chronic pain

- ☐ Nausea
- ☐ Constipation
- ☐ Discharge
- ☐ Shortness of breath
- ☐ Itching

- ☐ Incontinence
- ☐ Low-grade fever
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Other_____

How would you describe your current stress level? Please Identify major stressors in your life.

- ☐ Low
- ☐ Moderate
- ☐ High

Please list any medications, vitamins or supplements you are taking:

HEAD, EYES, EARS, NOSE, THROAT

Check any that apply:

- ☐ Glasses
- ☐ Headaches/ migraines
- ☐ Blurred vision/ itchy or red eyes
- ☐ Poor hearing
- ☐ Swollen glands
- ☐ Mouth/ tongue/ lip sores
- ☐ Excessive phlegm:
  Color: _____
  Consistency: _____

- ☐ Eye strain/pain
- ☐ Spots/ floaters in vision
- ☐ Sinus problems
- ☐ Recurrent lump in throat
- ☐ Gum problems
- ☐ Dizziness or vertigo
- ☐ Ear ringing/ deafness
- ☐ Jaw or facial pain/ TMJ

- ☐ Night blindness
- ☐ Earache
- ☐ Dry mouth/ throat
- ☐ Glaucoma/cataract
- ☐ Excessive saliva
- ☐ Grinding teeth
- ☐ Jaw clicks
- ☐ Other _____

RESPIRATORY & CIRCULATORY

Check any that apply:

- ☐ Tight chest
- ☐ Low blood pressure
- ☐ Palpitations/ irregular heartbeat
- ☐ Breathing difficulties
- ☐ Other _____
- ☐ Asthma/wheezing
- ☐ Chest pain
- ☐ Cough
- ☐ Swollen hands/feet
- ☐ Varicose veins
- ☐ Fainting

GASTROINTESTINAL

Check any that apply:

- ☐ Belching/ hiccups
- ☐ Constipation
- ☐ Undigested food in stool
- ☐ Intestinal pain or cramping
- ☐ Sensitive Stomach/ indigestion
- ☐ Vomiting/ nausea
- ☐ Heavy appetite
- ☐ Bloody or black stools
- ☐ Anal fissures
- ☐ Other _____
- ☐ Frequent hunger
- ☐ Rectal pain
- ☐ Gas/ bloating
- ☐ Gallstones
- ☐ Acid regurgitation
- ☐ Low appetite
- ☐ Sticky or clay-like stools
- ☐ Incomplete/ irregular bowels
- ☐ Itching or burning anus
- ☐ Hemorrhoids
- ☐ Bad breath
- ☐ Mucus in stools
- ☐ IBS
- ☐ Stomach pain/ ulcers
- ☐ Hiccups
- ☐ Trouble swallowing
- ☐ Hernia

GENITOURINARY

Check any that apply:

- ☐ History of UTI
- ☐ Prostate cancer
- ☐ Benign Prostate Hyperplasia
- ☐ Increased/ decreased libido
- ☐ Nocturnal emission
- ☐ Other _____
- ☐ Premature ejaculation
- ☐ Kidney/ Bladder stones
- ☐ Incontinence or bedwetting
- ☐ Abnormal urine flow
- ☐ Wake too often to urinate
- ☐ Burning/ painful urination
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Impotence

SKIN & HAIR

Check any that apply:

- ☐ Rashes/ hives
- ☐ Dandruff
- ☐ Hair loss
- ☐ Itchy, dry skin
- ☐ Other_____
- ☐ Skin numbness
- ☐ Ulcerations/ abscesses
- ☐ Eczema
- ☐ Fungal infection
- ☐ Acne
- ☐ Psoriasis
- ☐ Warts or corns

GYNECOLOGY & REPRODUCTION

Check any that apply:

- ☐ Irregular period
- ☐ Pain during ovulation
- ☐ Menstrual cramps
- ☐ Menstrual clots
- ☐ Vaginal odor
- ☐ Strong menstrual odor
- ☐ Pain during intercourse
- ☐ Sexually transmitted infection
- ☐ Breast tenderness/ swelling
- ☐ Vaginal discharge
  - Color: _____
  - Consistency: _____
- ☐ Breast lumps
- ☐ PMS
- ☐ Genital sores

Menopause (age):

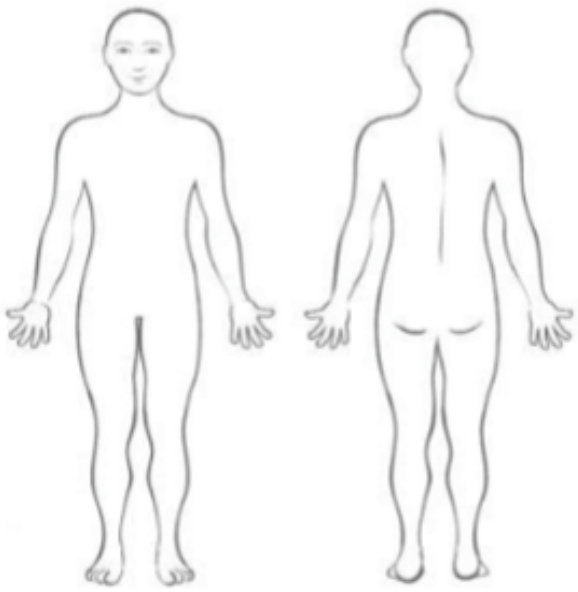
Number of pregnancies:

Number of live births:

Current form of birth control:

PAIN & DISCOMFORT

Do you have any pain, discomfort or known current or previous injury?
(Mark on diagram)



How long have you been experiencing the pain?

- ☐ Within last week
- ☐ Within last 3 months
- ☐ 3-6 months
- ☐ 6 months- 1 year
- ☐ More than 1 year

Type of pain:

- ☐ Sharp
- ☐ Aching
- ☐ Throbbing
- ☐ Numb
- ☐ Cramps
- ☐ Stiffness
- ☐ Dull
- ☐ Shooting
- ☐ Burning
- ☐ Tingling
- ☐ Swelling
- ☐ Other _____

How often do you have this pain?

Is there a time of day when the pain is worse?

Are any of the following activities limited by your pain?

- ☐ Standing
- ☐ Sleeping
- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Specific movements: _____

What helps relieve the pain?

- ☐ Cold
- ☐ Heat
- ☐ Medication
- ☐ Massage
- ☐ Other _____

Informed Consent Form

Treatment: Acupuncture is performed by the insertion of per-sterilized, disposable needles through the skin, and/or the application of heat or electrical simulation to the skin, at certain points on the body. Chinese herbs may be recommended for internal or external use. Although rare, certain side effects may result from acupuncture or the use of herbs. Please read the following statements about the types of treatment offered at this clinic and their potential risks. Your practitioner will explain the treatment that is planned for your condition and answer any questions you have about it.

Procedures and products that may apply to my treatment: Acupuncture needles, tui na massage, herbs, and acupressure.

Potential risks and side effects of acupuncture and Oriental medical procedures include: Minor bruising or burning, possible pain at the site of insertions, needle sickness (for those with extreme sensitivity to needles), bending or breaking of needles, infection, and the risk of needling in the vicinity of an infection, possible reaction to an herb or herbal formula.

- I understand the treatment modalities that may be applied in this clinic, and have been informed of the potential risks of said treatment.

Payment for service:

- I understand that payment is due at the time I receive treatment.

Patient's signature: Date:

_____ _____

CONSENT TO TREAT A MINOR CHILD

I authorize the acupuncturist and/or whomever they designate as assistants to administer acupuncture care as deemed necessary to my _____ (relationship).

Patient's name:

_____

Adult's Signature: Date:

_____ _____