

ACUPUNCTURE AND CHINESE MEDICINE CENTER

Edina Professional Building, Suite 308 • 7250 France Avenue South • Edina MN 55435

Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

Date: _____

Name: _____ Age _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____

Telephone (H) _____ (W/C) _____

Guardian (if under 18) _____ Email Address _____

Male ___ Female ___ Height _____' _____" Weight _____ lb Occupation _____

Married ___ Divorced ___ Single ___ Separated ___ Widowed ___

Ethnic: Caucasian ___ African American ___ Asian ___ Native American ___ Other _____

How did you hear about our office? _____

Emergency Contact _____ Tel: _____ Relation _____

Have you been treated by acupuncture or oriental medicine before? Yes ___ No ___

If yes, when _____ where _____ and for what reason _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief for pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care).

Please check the type of care desired so that our acupuncturist may be guided by your needs and desires when recommending your treatment program.

___ Relief
Care

___ Corrective
Care

___ Check here if you want the Acupuncturist
to select the type of care appropriate
for your condition.

Patient Signature _____ Date _____

Name: _____ Date: _____

YOUR MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE TO YOU:

#1 _____ __Severe __Moderate __Slight

Describe your symptoms: _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you've received for this condition? _____

#2 _____ __Severe __Moderate __Slight

Describe your symptoms: _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you've received for this condition? _____

#3 _____ __Severe __Moderate __Slight

Describe your symptoms: _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you've received for this condition? _____

YOUR PAST MEDICAL HISTORY (please include date and length)

How was your childhood health? _____

Diabetes _____ High Cholesterol: _____ Thyroid Disorders _____ Allergies: _____

Asthma _____ Heart Disease _____ Hepatitis _____ Rheumatic fever _____

Cancer: _____ High Blood Pressure _____ Others _____

Surgeries (list type of and date) _____

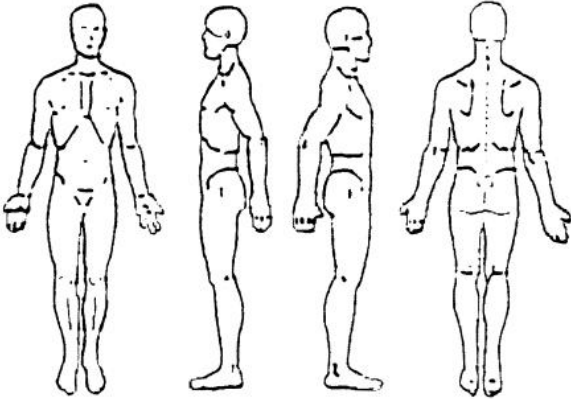
Allergies (drugs, chemicals, food) _____

Recent tests: (please indicate test results and date below. Please bring in your lab reports copies)

Please list your current medications: _____

DO YOU HAVE PAIN? YES NO

If Yes, please describe pain for each area (please mark on diagram)



1. My worst pain area is my _____
 The pain is constant / intermittent / dull aching / sharp / burning
 In what degree on a scale of 1-10 (10 = worst): _____
 Aggravated By: pressure / cold / heat / exercise
 Alleviated By: pressure / cold / heat / exercise
 Do you take pain medication? Dose _____, _____ days/wk

2. My next to worst pain area is my _____
 The pain is constant / intermittent / dull aching / sharp / burning
 In what degree on a scale of 1-10 (10 = worst): _____
 Aggravated By: pressure / cold / heat / exercise
 Alleviated By: pressure / cold / heat / exercise
 Do you take pain medication? Dose _____, _____ days/wk

On a Scale of 1-10 (10 being the worst), Estimate the Level of the Symptoms You Currently Have

General

- Hot body temperature
- Cold body temperature
- Sweat easily
- Night sweat
- Low energy
- Easily catch colds
- Strong thirst (cold or hot)
- Thirst, no desire to drink

Liver/Gallbladder

- Irritability/Anger
- Depression/Stress
- Headaches/Migraines
- Visual Problems
- Red/Dry/Itchy Eyes
- Gallstones (history or current)
- Dizziness
- Blurred vision/spots
- Feeling of lump in throat
- Clenching of teeth at night
- Muscle cramping/twitching
- Tension
- Poor Circulation
- Soft/Brittle nails/hair
- Emotional eater
- Breast tenderness

Heart/Small Intestine

- Heart palpitations
- Chest pains
- Insomnia/Sleep problems
- Restlessness/Agitation
- Vivid Dreams

- Anxiety
- Mouth/tongue sores
- Poor circulation
- Lack of joy/humor

Spleen/Stomach

- Abdominal Pain
- Heaviness anywhere in body
- Fatigue/Worse after eating
- Hard to get up in the morning
- Edema (Swelling)
- Muscles feel tired often
- Decreased/Increased appetite
- Crave Sweets
- Difficulty digesting oily foods
- Nausea/Vomiting
- Gas/Belching
- Gastritis/Heartburn
- Insulin Sensitivity/Hypoglycemia
- Brain Foggy
- Diarrhea/ Constipation
- Over-Thinking/Worry
- Colic/Indigestion

Lung/Large Intestine

- Allergies
- Arm/shoulder pain
- Asthma
- Dry Cough
- Cough /sneeze/phlegm
- Nasal Discharge
- Post-nasal drip/mucus
- Sinus infection/congestion

- Shortness of Breath
- Grief/Sadness
- Smell problems
- Skin rashes/Hive
- Low Resistance to Colds/Flu
- Smoke Cigarettes

Kidney/Urinary Bladder

- Urinary problems
- Bladder Infection
- Lack of bladder control
- Edema/water ret.
- Weakness/Pain in low back
- Weak/Sore knees
- Decreased bone density
- Feel cold easily
- Low/Excess sex drive
- Poor memory
- Loss of hair
- Hearing problems
- Infertility/sterility
- Impotence/libido
- Lack stamina
- Tinnitus (low)
- Fear/depression
- Hot flush/Night sweating
- Cavities
- Craving/Avoiding salty foods
- Kidney stone (history/current)

Patient Initial: _____

Date: _____

YOUR LIFESTYLE:

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____, None _____
 Do you smoke cigarettes? ___ Yes, ___ No; How many/day? _____ How many years? ___ Quit ___ When _____
 Do you drink alcohol? ___ Yes, ___ No; If Yes, How many drinks per week? _____
 Do you exercise? ___ Yes, ___ No; (describe _____)
 On a scale of 1-10 (10=worst), estimate the level of stress you feel due to your **work** _____, your **health** _____

WOMEN ONLY (Menstruation and Pregnancy History): Age of menopause _____
 (INFERTILITY WOMEN, Please fill out our "Fertility History and Information Form" as well.)

Age of first menstruation _____ Are you pregnant? Yes / No Average days of flow _____
 Number of pregnancy _____ Number of birth _____ Bleeding/spotting between Menses ___
 # of days between menses _____ Practice birth control? Yes / No 1st day of your last period _____

Do you experience any of the following pre-menstrual syndromes (PMS)?
 ___ Nausea ___ Vomiting ___ Water retention ___ Breast tenderness ___ Food craving ___ Anxiety
 ___ Irritability ___ Depression ___ Mood swing ___ Poor sleep ___ Headaches ___ Migraines
 ___ Diarrhea ___ Pain, Where _____ (always /sometimes /recently /in the past)

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, other)							
Amount of flow (normal, heavy, light, scanty)							
Pain/Cramps (a scale of 1-10)							
Clots (Large, small, dark red)							
Others							

MEN ONLY:
 (INFERTILITY MEN, Please fill out our "Fertility History and Information Form" as well.)

___ Swollen testes ___ Testicular pain ___ Impotence ___ Premature ejaculation ___ Infertility (male)
 ___ Feeling of coldness or numbness in external genitalia Other: _____

ALL PLEASE FILL OUT:

Other Comments: _____

Patient Signature: _____ Date: _____

ACUPUNCTURE AND CHINESE MEDICINE CENTER

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Phone: (952) 820-0877

CONSENT FORM

I, the undersigned, hereby authorize the acupuncturists at the Acupuncture and Chinese Medicine Center (ACM Center), to perform the following specific procedures:

Acupuncture: Insertion of special sterilized needles through the skin, into the underlying tissues at specific points on the surface of the body.

Cupping: A technique that helps relieve symptoms and draws out toxins, involving filling a glass cup with hot air and placing it on the skin to create a vacuum suction.

Tuina: an ancient massage used to treat a wide variety of common disharmonies.

Chinese Herbs and Dietary Advice: Based on traditional Chinese medicine theory. These herbs may be given, to take internally or externally in the form of pills, powder, tinctures, pastes, or other forms.

I recognize the potential risk and benefit of these procedures as described below.

Potential risks: Discomfort, pain, numbness, tingling, infection and blistering at the site of procedure, needle sickness, nausea, vomiting, fainting, dizziness, broken needle, temporary discoloration of skin, loose bowels, abdominal cramping, and even possibly, temporary aggravation of symptoms existing prior to the acupuncture and herb treatment. Burns are a potential risk due to the use of heating lamps. Extremely rare risks include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). If I have severe bleeding disorders, pacemakers or become pregnant prior to treatment I will notify the acupuncturist who is caring for me. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

Potential benefits: Drugless relief of presenting symptoms and improved balance of bodily energies may lead to prevention or elimination of the presenting problem and strengthen the constitution.

With this knowledge, I voluntarily consent to the above procedures realizing that no guarantees have been given to me by the acupuncturists at the ACM Center, regarding the cure or improvement of my condition. I hereby, release the acupuncturists of the ACM Center from any and all liability, which may occur in connection with the above-mentioned procedures. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I acknowledge that all treatment records will be kept confidential in this office. I authorize the staff at ACM Center to leave messages at the following **telephone number** and/or **E-mail**:

Phone: (_____) _____

E-mail: _____

Signature

Date

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Cancellation and Rescheduling Policy

As a courtesy, we request a 72-hour notice of cancellation for a patient's first initial visit when unable to keep the appointment. For follow up visits, if you need to cancel or reschedule your appointment, a 24-hour notice of cancellation is required. Therefore, we can make your time available to another person. If cancellation is made less than 24-hours before the appointment, you will be charged a cancellation fee of \$35.00. If you fail to show up for your appointment without notifying us, you will be charged a full visit fee.

Herb and Supplement Return and Exchange Policy

Returns and exchanges must be made within **60** days of receipt. They must be unopened, in good condition and not expired.

Payment Policy

Payment is expected at the time of your visit. We accept checks, Visa and Mastercard, or cash. We provide a monthly statement that you may use to get reimbursement from your health care flexible spending account (FSA).

Acupuncture is not always covered by health insurance; please contact your insurance company to verify benefits for acupuncture treatment provided by a licensed Acupuncturist. You must inform us when you schedule your initial visit if insurance is going to be billed. We would need to have your basic information to verify insurance coverage prior to your appointment. We will collect your co-pay or estimated portion at the time of your visit.

As a service to you, providing you have acupuncture coverage and we are not a PPO provider, we will send claims to your health insurance or create a monthly statement for insurance reimbursement.

This policy was established for the benefit of both clients and practitioners. We appreciate your cooperation in this matter, and look forward to serving you in the future.

I have read and understand the above information of payment and cancellation policy.

Signature of Patient

Date

NewPatientHealthHx Rev. 1602