ACUPUNCTURE AND CHINESE MEDICINE CENTER

7600 Parklawn Avenue, Suite 321, 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 _____

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)
_____

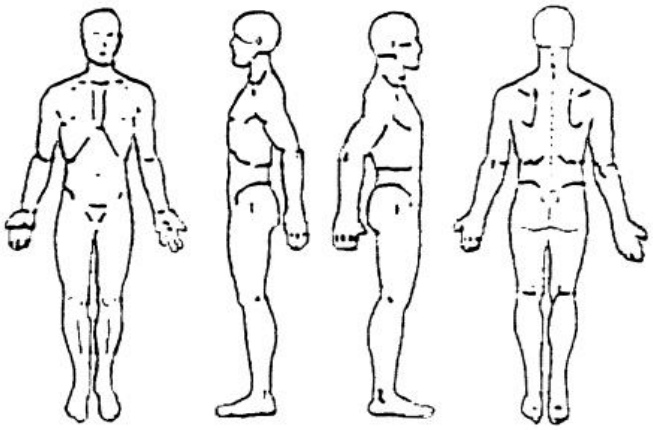
Please list your current medications and Supplements:

_____

Patient Initial: _____

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

7600 Parklawn Avenue, Suite 321, Edina MN 554355
Phone: (952) 820-0877

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 to avoid cancellation charge. Therefore, we can make your time available to another person.

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 check, cash or electronic payment (Zelle). There is service fee for **ALL cards transactions**. 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 the health insurance; please contact your health insurance company to verify your acupuncture treatment benefits. We can provide an itemized receipt if you would like to submit it to your insurance for reimbursement. Our office **DOES NOT** bill insurance directly.

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 understood the above information of payment and cancellation policy.

_____ _____

Signature of Patient Date

Policy Rev. 2306