Medical History

All information is confidential and shall not be shared without your written consent.

320.656.1010
www.acupuncturenaturalhealth.com

Name ____

Today's Date ______________________ Date of Birth __________

Address ____

____

Work phone __________________ Home phone __________________

Cell phone__________________ Email __________________

May we contact you at work? ______________________________

May we email you? ______________________________

How did you hear about our clinic? ______________________________

Main complaint(s) for which you are seeking relief ______________________

____

Have you been given a diagnosis for this condition? If so, what?

____

What kinds of treatments have you tried, and to what extent have they helped you?

____

Do you have or have you ever been diagnosed with HIV/AIDS, Hepatitis B, Hepatitis C?

❑ Yes ❑ No If yes, what is your current status? ______________________

List any recreational or street drugs you use ______________________

____

Are you in recovery for a chemical addiction? If so, what type? ______________

Please note dates of all that apply to your past medical history:

Cancer__________ Diabetes__________ High Blood Pressure__________

Heart Disease__________ Seizures__________ Rheumatic Fever__________

Thyroid Disease __________ Venereal Disease__________

Chemical exposure (pesticides, herbicides, work related/ personal use) ______________________

____

Major surgeries(please list dates and type of surgery) ______________________________________

____

Significant trauma (falls, auto accidents, etc.) ____

____

Medications, vitamins and supplements taken within the past two months

____

Please list quantity and frequency of use for the following items:

Tobacco __________ per __________ Coffee __________ per__________

Alcohol __________ per __________ Sugar __________ per__________

Other ____________

How many ounces of water do you consume each day? _________________________________

Personal Traditional Chinese Medical Assessment

Please check the box in front of all responses describing your condition.

Thermal Perception

❑ Frequently feel warm
❑ Frequently feel cool
❑ Feel warm at night
❑ Perspire at night
❑ Feel cold at night
❑ Have cold hands and feet
❑ Feel hot in my face, chest or hands.
❑ Have a strong thirst for cold beverages
❑ Have a strong thirst for hot/warm beverages

Energy

❑ I have plenty of energy.
❑ I am tired frequently.
❑ I have and energy drop at__________time of the day.
❑ I take__________daily nap(s) for__________minutes per nap.
❑ I am a slow starter in the morning.
❑ I rely on caffeine to get me started in the morning.
❑ I am a " night owl".
❑ My energy drops after I eat certain foods (list type of foods):

____

____

Sleep

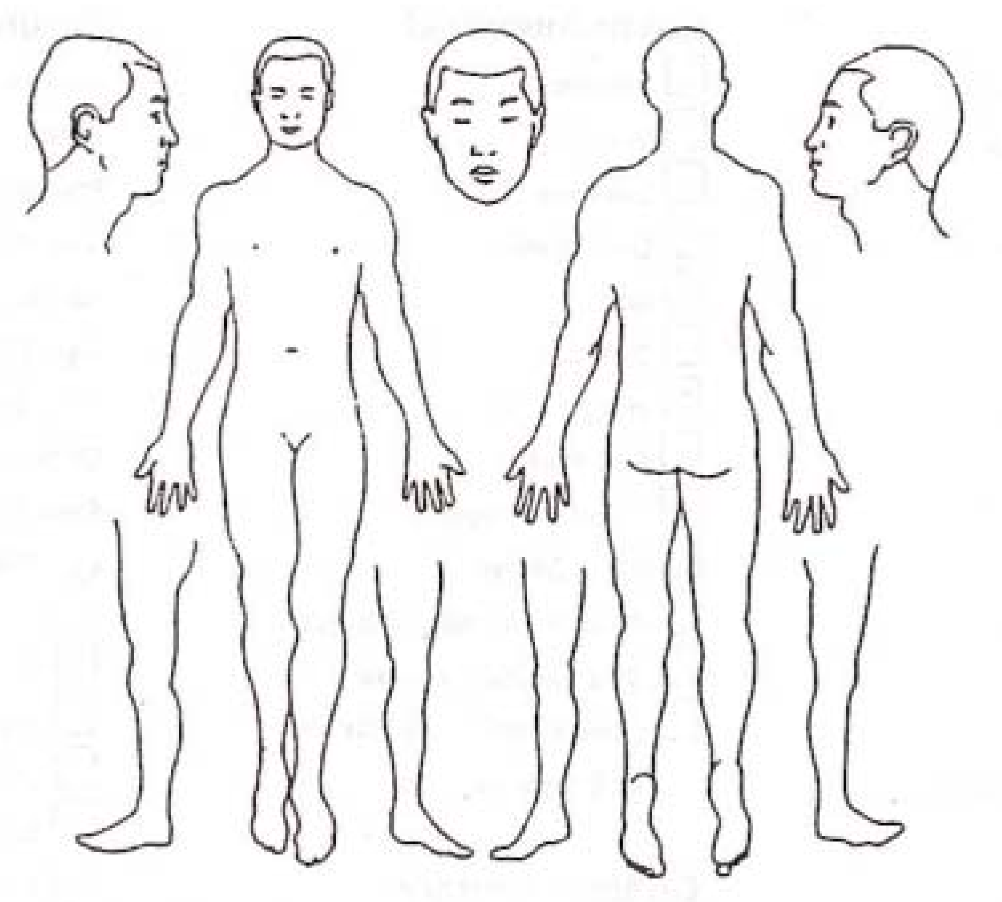
I sleep________hours per night, on average.

I awaken________times at night on average (not counting bathroom breaks).

❑ I never feel rested.
❑ I have difficulty falling to sleep.
❑ I awaken frequently during the night
❑ I am a light sleeper.
❑ I can sleep through anything and not wake up.
❑ I sleep in on weekends to catch up on missed sleep.
❑ Pain prevents me from sleeping.

Pain

Please indicate your areas of pain on the anatomical diagram.



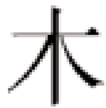
Pain

❑ My pain is unbearable and nothing helps it.
❑ My pain is alleviated by resting.
❑ My pain is alleviated by movement and stretching.
❑ My pain is worse at night.
❑ My pain is worse in the morning.
❑ Heat decreases my pain.
❑ Cold decreases my pain.
❑ I take prescribed medication to control pain.
❑ I take NSAIDs and Over-the-Counter medication to control pain.
❑ I have only minor aches and pains.
❑ I rarely, if ever, experience pain.

Stress

❑ My stress levels are very high.
❑ My relationship with my spouse/partner causes me stress.
❑ Work is stressful.
❑ Many of my health complaints improve when I take a vacation.
❑ I have high blood pressure.
❑ I have a rapid heart rate, heart palpitations or skip heart beats.
❑ I currently am unemployed.
❑ I dislike my job.
❑ I have very little stress in my life.

Please check the boxes in front of all symptoms you experience.



Liver/Gallbladder

❑ Blurry Vision
❑ "Floaters", "seeing spots", or other visual disturbances
❑ Dry Eyes
❑ Cataracts
❑ Red Eyes
❑ Migraine headaches
❑ Stress headaches
❑ Headaches that frequently occur at the base of your skull
❑ Headaches effecting your eyes or temples
❑ Feeling frustrated
❑ Feeling Angry
❑ Sensation of having a lump stuck in your throat
❑ Tend to have a "short fuse" or react angrily to situations.
❑ Feeling full or distended beneath your rib cage
❑ Pain beneath the ribs, often worse after eating
❑ Right-sided pain or discomfort
❑ Nausea after eating fatty foods
❑ Depression
❑ Shoulder pain (please circle: left and/or right)
❑ Constipation alternating with loose stools
❑ Have Irritable Bowel, Crohn's or Ulcerative Colitis

❑ Have a sour or bitter taste in your mouth
❑ Crave sour or bitter flavors
❑ Have health issues that worsen in the spring
❑ Grinding teeth or TMJ Diagnosis
❑ Brittle nails
❑ Ridges on your nails
❑ Inflexible muscles or tight tendons
❑ Difficulty making decisions/indecisive
❑ History of gallstones

土 Spleen/Stomach

❑ Bruise easily
❑ Crave sweets
❑ Have a history of antibiotic use
❑ Tend to feel bloated after eating starchy foods
❑ Tend to feel tired after eating starchy foods
❑ Feeling muscle weakness
❑ History of significant blood loss (trauma/childbirth)
❑ Tend to have loose bowel movements
❑ Poor appetite
❑ Weight gain in the past six months
❑ Have been diagnosed with Type II diabetes or Pre-diabetes
❑ Frontal headaches
❑ Have symptoms that worsen in late Summer.

水 Kidney/Urinary Bladder

❑ Low back pain
❑ Knee pain
❑ Joint pain
❑ Diagnosed with arthritis
❑ Ringing in the ears
❑ Poor hearing
❑ Feel anxious
❑ Feel afraid
❑ Have a history of stressful periods in your life
❑ Do not like making changes in your life
❑ Decrease in libido
❑ Poor memory
❑ Frequently feel cold
❑ Prefer warmth over cooler temperatures.
❑ Have health problems that worsen in the Winter.

❑ Loss of hair
❑ Dry or brittle hair
❑ Frequent urination
❑ History of kidney stones
❑ Urgent urination
❑ Awakening at night to urinate__________times per night)
❑ Have symptoms that worsen in the winter.

火 Heart/Small Intestine

❑ Difficulty falling asleep
❑ Frequent awakening
❑ Heart Palpitations
❑ Difficulty speaking
❑ Feeling light headed
❑ Poor balance
❑ Insomnia
❑ Forgetfulness
❑ Pale complexion
❑ Numbness in limb(s)
❑ Tremors
❑ Fixed or stabbing pain in the body or upper body
❑ Have symptoms that worsen in Mid-Summer
❑ Recently experienced " broken-heartedness".

金 Lung/ Large Intestine

❑ History of grief or loss that feels unresolved
❑ Change in skin texture
❑ Perspire easily with little or no exertion
❑ Acne, pimples or other skin blemishes
❑ Health conditions that frequently occur in the late Fall
❑ Prone to respiratory ailments
❑ Frequently have colds
❑ Tendency toward constipation
❑ Have symptoms that worsen in the Fall.
❑ Diagnosed with asthma (date________
❑ Allergies to (please list all that apply) ____

Women's Health Section

Date you completed your last menstrual cycle______________
Duration of menses________days
Length of your cycle in days (i.e. average 28-30 days)________days
❑ Irregular menstrual cycles
❑ Hysterectomy (partial/complete) on________
❑ Laparoscopy performed on________
Findings of laparoscopy ____
Can you tell when you ovulate? ❑ Yes ❑ No
If so, approximately on which day of your cycle do you ovulate? ______________________________
Are you in menopausal? ❑ Yes ❑ No
Do you have early menopausal symptoms? ❑ Yes ❑ No

Number of pregnancies __________________________ Number of births _______________________

Other conditions or procedures you would like to mention ____________________________________

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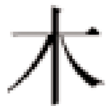

.iver/ Gallbladder

❑ Menstrual cramps
❑ Painful periods
❑ Ovarian cysts
❑ Uterine Fibroids
❑ Heavy menstrual flow on day(s)________
❑ Clotted blood with menses on day(s)________
❑ Dark red or maroon blood during period on day(s________
❑ PMS
❑ Breast tenderness or distention prior to or during menses
❑ Constipation before menses
❑ Alternating loose stools and constipation with period.
❑ Menstrual migraines
❑ Diagnosis of Endometriosis
❑ Unexplained Infertility
❑ Infertility due to structural or physical origin
❑ Difficulty conceiving
❑ Feel better following your menses.

土 **Spleen/Stomach**

- ❑ Light menstrual flow
- ❑ Short menstrual cycle lasting________days.
- ❑ Light colored or pale blood during your period.
- ❑ Feeling tired after your period.
- ❑ Loose stools with period.

水 **Kidney/Bladder**

- ❑ Night sweats________times per night
- ❑ Difficulty sleeping because of night sweats
- ❑ Hot flashes________times per day

OFFICE USE ONLY

Primary Dx: ____

Secondary Dx: ____

Treatment Principle: _______________________________________

Pts: ____

acupuncture inc.
& natural health

Prices and policies

Should you have to cancel an appointment, we require a 24 hour advance cancellation notice. We also understand that certain emergent situations prevent one from having 24 hours in which to cancel an appointment-- in those cases, a phone call informing us of your inability to make your appointment is appreciated.

Failure to keep your scheduled appointments and appointments cancelled without 24 hour notice (or a phone call in emergent situations) are subject to a $50.00 late fee.

You are responsible for all fees generated through services rendered at our clinic. Some insurance coverage exists for acupuncture (auto accident, Health Partners, approved worker's compensation cases), but patients not covered by insurance will need to make a payment in full upon completing each appointment. For your convenience, we accept cash, checks, Visa, Master Card, and Discover.

With the exceptions of auto insurance, approved worker's compensation cases and Health Partner's patients, insurance forms will not be submitted from our office to your insurance company. We will, however, provide you with the necessary paperwork and codes for you to submit your forms to your insurance company, if you so desire.

Your first office visit to our clinic includes a complete Health History review, a Traditional Chinese Medical assessment, and an acupuncture treatment. The duration of the first treatment is approximately 75 minutes and costs $99.00 (plus 2% MN Care Tax).

Repeat visits cost $72.00 (plus MN Care Tax) and take about 45-50 minutes to complete.

Metered parking is available on the street for fifty cents per hour. There is a parking ramp option, located on the north side of the Paramount theater, (located on the corner of 10th Avenue south and West St. Germain), for which we will validate parking tickets, should you choose this option— make sure to bring your ticket with you to your appointment.

For further information on acupuncture and frequently asked questions, please visit our website at www.acupuncturenaturalhealth.com

Office Location:
We are located approximately six blocks west of the Mississippi river, and two blocks north of Division (HWY 23), at the junction of West Saint Germain Street and Eighth Avenue South.