MINNESOTA COMMUNITY ACUPUNCTURE

HEALTH HISTORY

Date: ___ / ___ / _____

Name:		Sex:	Age:
Address:	City:	State:	Zip Code:
Home Phone #:	Other Phone #: Work Cell Other	Email:	
Date of Birth:	Emergency Contact	Emergency Contact Phone Number	
How did you hear of our clinic?:		Have you been treated by Acupuncture or Oriental Medicine Before? ☐ No ☐ Yes ___/___/___	

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ ago
Heat makes it: better no change worse
Cold makes it: Better no change worse
Damp weather: Better no change worse
Exercise / Activity: better no change worse

1 |——————|——————| 10

2 _____

When did this start? _____ ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 |——————|——————| 10

3 _____

When did this start? _____ ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 |——————|——————| 10

HEALTH HISTORY

Check the box if you have / had the condition and note the year it started.
Check the box if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer type(s)? _____	☐	_____	☐
Diabetes	☐	_____	☐
Hepatitis	☐	_____	☐
High Blood Pressure	☐	_____	☐
Heart Disease	☐	_____	☐
Stroke	☐	_____	☐
Seizure Disorder	☐	_____	☐
Thyroid Disease	☐	_____	☐
Asthma	☐	_____	☐
Pacemaker	☐	_____	☐
Osteoporosis	☐	_____	☐
Herpes	☐	_____	☐
AIDS / HIV	☐	_____	☐
Other STD	☐	_____	☐
Rheumatic Fever	☐	_____	☐
Alcoholism	☐	_____	☐
Allergies type(s)? _____	☐	_____	☐
Mental Illness	☐	_____	☐
Kidney Disease	☐	_____	☐
Anemia	☐	_____	☐

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? ☐Yes ☐No

If so, what and how often:

_____
_____
_____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)

Describe w/ dates:

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

_____
_____
_____

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

_____
_____
_____

MINNESOTA COMMUNITY ACUPUNCTURE

HEALTH HISTORY for MEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD ——— HOT

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness
- ☐ Thirst for cold / hot drinks
- ☐ Thirst, no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst
- ☐ Night sweats
- ☐ Unusual sweats

When_____am / pm

Where on body_____

- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY ——— OILY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry brittle nails
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose / Nosebleeds

Where on your body?:

- ☐ Edema / Swelling _____
- ☐ Rashes _____
- ☐ Itching _____
- ☐ Dandruff
- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain / loss

DIGESTION

DIARRHEA ——— CONSTIPATION

BM: How often? _____x / every _____days

Stools keep shape? ☐Y ☐N

- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion
- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger
- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

ENERGY

LOW ——— HIGH

- ☐ Sudden energy drop

Time of day: _____ am / pm

- ☐ Energy drop after eating
- ☐ Fatigue
- ☐ Dependence on caffeine / stimulants
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easy
- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches _____x / week

SLEEP

hours per night _____

- ☐ Difficulty falling asleep
- ☐ Wake ___x/ night @_____am / pm
- ☐ Wake to urinate How often?_____
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

EYES, EARS NOSE THROAT

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Sinus congestion
- ☐ Phlegm (color_____)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

URINARY

Fluid in = fluid out? ☐Y ☐N

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting / stopping
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine

REPRODUCTIVE

Are you sexually active? ☐Y ☐N

Change in Sex Drive? ☐Y ☐N

- ☐ Erectile dysfunction
- ☐ Sores on genitals
- ☐ Discharge
- ☐ Premature ejaculation
- ☐ Prostate disease
- ☐ Genital Pain
- ☐ Jock Itch
- ☐ Vasectomy
- ☐ Hernia
- ☐ Hemorrhoids

MINNESOTA COMMUNITY ACUPUNCTURE

Informed Consent Form

Voluntary Consent

I hereby voluntarily request and consent to be treated, or give permission for my child/ward to be treated, with acupuncture; electro-acupuncture; acupressure and other techniques based on Traditional Asian Medicine. I understand I may be given recommendations on diet, lifestyle and nutritional or herbal supplements and it is my decision whether or not to follow these recommendations. I understand I may be treated with the insertion of needles or other non-insertion techniques; electrical stimulation; or touch/palpation.

I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

Possible Side Effects/Healing Reactions

I understand that these treatments may result in certain side effects, including local bruising; slight bleeding; fainting; temporary pain or discomfort; and temporary aggravation of symptoms existing prior to treatment.

Medical Referral

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner does not substitute for appropriate medical treatment by a licensed physician. If there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I am advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments. I certify that I will inform MNCA of all known physical, mental, and medical conditions and medications, including possible pregnancy, and that I will notify MNCA of any changes.

Infectious Disease/Clean Needle Procedures

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterilized, prepackaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use. I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have the right to refuse any treatment or procedure.

Payment and Cancellation Policies

Current fees are: Initial visit = $ 25 Follow-up visits= $ 15 - $ 35

Full payment is expected at the time services are rendered.

A $30 fee is charged for the first check returned by the bank. If a second check is returned, subsequent payments must be cash.

If you must cancel your appointment, we require a 24 hour notice to avoid a $ 15 cancellation fee.

_____

Patient Name

_____ _____

Signature of Patient or Representative Date

Minnesota Community Acupuncture
Notice of Privacy Practices, Version 1.1

Patient Acknowledgement

Right to Obtain a Copy of the Notice: You have the right to ask for and get a paper copy of this notice and any revisions we make to the notice at any time. Revised notices are also available online at www.minnca.com

As indicated by my signature below I hereby acknowledge receipt and understanding of the Notice of Privacy Practices.

Print Patient Name: _____

Signature of Patient or Person Authorized to Consent: _____

Relationship or Authority of Representative: _____

Date: _____