



# 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? <input type="checkbox"/> No <input type="checkbox"/> 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		YOU	Year	FAMILY
Cancer type(s)?	<input type="checkbox"/>	_____	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	_____	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	_____	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	_____	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	_____	<input type="checkbox"/>	AIDS / HIV	<input type="checkbox"/>	_____	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	_____	<input type="checkbox"/>	Other STD	<input type="checkbox"/>	_____	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	_____	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	_____	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	_____	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	_____	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	_____	<input type="checkbox"/>	Allergies type(s)?	<input type="checkbox"/>	_____	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	_____	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	_____	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	_____	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	_____	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	_____	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	_____	<input type="checkbox"/>

## 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 WOMEN



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.

<p style="text-align: center;"><b>COLD</b></p> <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Chills <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Thirst for cold / hot drinks <input type="checkbox"/> Thirst, no desire to drink <input type="checkbox"/> Absence of thirst <input type="checkbox"/> Excessive thirst	<p style="text-align: center;"><b>HOT</b></p> <input type="checkbox"/> Night sweats <input type="checkbox"/> Unusual sweats <i>When _____ am / pm</i> <i>Where on body _____</i>	<input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <input type="checkbox"/> Hot at night
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**MOISTURE**

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

<p style="text-align: center;"><b>DRY</b></p> <input type="checkbox"/> Dry skin <input type="checkbox"/> Dry hair <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry brittle nails	<input type="checkbox"/> Dry mouth <input type="checkbox"/> Dry lips <input type="checkbox"/> Dry throat <input type="checkbox"/> Dry nose / Nosebleeds	<p style="text-align: center;"><i>Where on your body?:</i></p> <input type="checkbox"/> Edema / Swelling _____ <input type="checkbox"/> Rashes _____ <input type="checkbox"/> Itching _____ <input type="checkbox"/> Dandruff	<p style="text-align: center;"><b>OILY</b></p> <input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain / loss
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**DIGESTION**

<p style="text-align: center;"><b>DIARRHEA</b></p> <p>BM: How often? _____ x / every _____ days</p> <p>Stools keep shape?    <input type="checkbox"/> Y    <input type="checkbox"/> N</p> <input type="checkbox"/> Alternating diarrhea & constipation (IBS) <input type="checkbox"/> Indigestion	<input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Poor appetite	<input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bad breath <input type="checkbox"/> Heartburn <input type="checkbox"/> Excessive hunger	<p style="text-align: center;"><b>CONSTIPATION</b></p> <input type="checkbox"/> Dry Stools <input type="checkbox"/> Difficult to pass <input type="checkbox"/> Tired after BM <input type="checkbox"/> Foul smelling stools
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**ENERGY**

<p style="text-align: center;"><b>LOW</b></p> <input type="checkbox"/> Sudden energy drop <i>Time of day: _____ am / pm</i> <input type="checkbox"/> Energy drop after eating <input type="checkbox"/> Fatigue	<input type="checkbox"/> Dependence on caffeine / stimulants <input type="checkbox"/> Wired / ungrounded feeling <input type="checkbox"/> Body / Limbs feel heavy <input type="checkbox"/> Body / Limbs feel weak	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Blood pressure High / Low <input type="checkbox"/> Bleed / Bruise easy	<p style="text-align: center;"><b>HIGH</b></p> <input type="checkbox"/> Hard to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Dizziness / lightheaded <input type="checkbox"/> Headaches _____ x / week
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**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?

<input type="checkbox"/> Anger	<input type="checkbox"/> Grief
<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Joy
<input type="checkbox"/> Worry	<input type="checkbox"/> Fear
<input type="checkbox"/> Obsessive thinking	<input type="checkbox"/> Timid / shy
<input type="checkbox"/> Sadness	<input type="checkbox"/> Indecision

**EYES, EARS NOSE THROAT**

<input type="checkbox"/> Poor vision	<input type="checkbox"/> Poor hearing
<input type="checkbox"/> Night blindness	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Excess earwax
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Dental problems
<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Phlegm ( <i>color</i> _____)	<input type="checkbox"/> Cough

**MENSES**

Age at first menses: \_\_\_\_\_

Length of full cycle: \_\_\_\_\_ days

Length of menses: \_\_\_\_\_ days

Last menses start date: \_\_\_\_\_ / \_\_\_\_\_

# of pregnancies: \_\_\_\_\_

# of births: \_\_\_\_\_ premature \_\_\_\_\_

# of abortions / miscarriages: \_\_\_\_\_

**MENOPAUSE**

Age at last menses : \_\_\_\_\_     Hot flashes \_\_\_\_\_ x / day     Vaginal dryness

Year changes began: \_\_\_\_\_     Night sweats \_\_\_\_\_ x / week     Loss of sex drive

<input type="checkbox"/> Heavy periods	<input type="checkbox"/> Cramps	<input type="checkbox"/> Mood changes
<input type="checkbox"/> Light periods	<input type="checkbox"/> Before bleeding	<input type="checkbox"/> Fatigue w/ menses
<input type="checkbox"/> Painful periods	<input type="checkbox"/> First day	<input type="checkbox"/> Digestive changes w/ menses
<input type="checkbox"/> Irregular periods	<input type="checkbox"/> During period	<input type="checkbox"/> Midcycle spotting
<input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS)	<input type="checkbox"/> Clots	<input type="checkbox"/> Yeast infections
	<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Birth control pill (hormonal)



## 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](http://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: \_\_\_\_\_