

**ACUPUNCTURE AND CHINESE MEDICINE CENTER**  
**Patient's Health History Information Form**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ B/C \_\_\_\_\_

Sex: M / F      Marital Status: M S W D      Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ Referred by \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Tel: \_\_\_\_\_ Relation \_\_\_\_\_

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

If yes, when \_\_\_\_\_ where \_\_\_\_\_ and for what reason \_\_\_\_\_

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**Main problem(s) you need help with** \_\_\_\_\_

When did this problem begin (be specific) \_\_\_\_\_ caused by \_\_\_\_\_

To what extent does this problem interfere with your daily activities (work, sleep, eat, etc.)  
\_\_\_\_\_

Have you been given a diagnosis or treatment for this problem? If so, what? (be specific)  
\_\_\_\_\_

Medicine taken within the last two months (vitamins, drugs, herbs, etc.): \_\_\_\_\_  
\_\_\_\_\_

**YOUR PAST MEDICAL HISTORY** (please include date and length)

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) \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

\_\_\_ Asthma                      \_\_\_ Cancer                      \_\_\_ Diabetes                      \_\_\_ Heart Disease  
\_\_\_ Stroke                      \_\_\_ High Blood Pressure                      Other \_\_\_\_\_

**YOUR LIFESTYLE:**

\_\_\_ Alcohol      \_\_\_ Tobacco      \_\_\_ Stress      Regular exercise \_\_\_\_\_ days/wk

Please Check Any Symptoms You Have Had in the Last Three Months

General

- \_\_\_\_\_ Fevers
- \_\_\_\_\_ Chills
- \_\_\_\_\_ Fatigue
- \_\_\_\_\_ Localized weakness
- \_\_\_\_\_ Sweat easily
- \_\_\_\_\_ Night sweat
- \_\_\_\_\_ Bruise or bleeding easily
- \_\_\_\_\_ Odd tastes or smells
- \_\_\_\_\_ Strong thirst (cold or hot)
- \_\_\_\_\_ Thirst, no desire to drink
- \_\_\_\_\_ Poor appetite
- \_\_\_\_\_ Cravings
- \_\_\_\_\_ Poor sleeping
- \_\_\_\_\_ Weight loss
- \_\_\_\_\_ Weight gain

Skin and Hair

- \_\_\_\_\_ Rashes
- \_\_\_\_\_ Itching
- \_\_\_\_\_ Ulcerations
- \_\_\_\_\_ Hives
- \_\_\_\_\_ Pimples
- \_\_\_\_\_ Loss of hair
- \_\_\_\_\_ Other \_\_\_\_\_

Head, Eyes, Ears, Nose  
and Throat

- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Migraines
- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Where \_\_\_\_\_
- \_\_\_\_\_ Facial pain
- \_\_\_\_\_ Poor vision
- \_\_\_\_\_ Eye strain or pain
- \_\_\_\_\_ Eye dryness
- \_\_\_\_\_ Sinus problems
- \_\_\_\_\_ Ringing in ears
- \_\_\_\_\_ Poor hearing
- \_\_\_\_\_ Sores on lips or tongue
- \_\_\_\_\_ Other \_\_\_\_\_

Cardiovascular

- \_\_\_\_\_ Pacemaker

- \_\_\_\_\_ High blood pressure
- \_\_\_\_\_ low blood pressure
- \_\_\_\_\_ Chest pain/discomfort
- \_\_\_\_\_ Heart palpitation
- \_\_\_\_\_ Swelling hands or feet
- \_\_\_\_\_ Cold hands or feet
- \_\_\_\_\_ Fainting
- \_\_\_\_\_ Other \_\_\_\_\_

Respiratory

- \_\_\_\_\_ Cough
- \_\_\_\_\_ Asthma/wheezing
- \_\_\_\_\_ Bronchitis
- \_\_\_\_\_ Coughing blood
- \_\_\_\_\_ Phlegm
- \_\_\_\_\_ Pneumonia
- \_\_\_\_\_ Pain with breathing
- \_\_\_\_\_ Other \_\_\_\_\_

Gastrointestinal (GI)

- \_\_\_\_\_ Nausea or vomiting
- \_\_\_\_\_ Gas
- \_\_\_\_\_ Heartburn
- \_\_\_\_\_ Belching
- \_\_\_\_\_ Indigestion
- \_\_\_\_\_ Constipation or Diarrhea
- \_\_\_\_\_ Bad breath
- \_\_\_\_\_ Blood in stools
- \_\_\_\_\_ Abdominal pain or cramps
- \_\_\_\_\_ Other \_\_\_\_\_

Genito-Urinary

- \_\_\_\_\_ Pain on urination
- \_\_\_\_\_ Urgent urination
- \_\_\_\_\_ Frequent urination
- \_\_\_\_\_ Unable to hold urine
- \_\_\_\_\_ Kidney stone
- \_\_\_\_\_ Impotency
- \_\_\_\_\_ Sores in genitals
- \_\_\_\_\_ Other \_\_\_\_\_

Obstetrics & Gynecology

- Number of pregnancies \_\_\_\_\_
- Number of birth \_\_\_\_\_
- Age at first menses \_\_\_\_\_
- Age at menopause \_\_\_\_\_

- Period between menses (days) \_\_\_\_
- \_\_\_\_\_ Irregular menses
- \_\_\_\_\_ Painful period
- \_\_\_\_\_ Psyche changes prior to menses
- \_\_\_\_\_ Clots in menses blood
- \_\_\_\_\_ Symptoms during/before menses  
headache/diarrhea/constipation
- \_\_\_\_\_ Vaginal sores
- \_\_\_\_\_ Breast Lumps
- \_\_\_\_\_ Breast cancer
- \_\_\_\_\_ Other \_\_\_\_\_

Musculoskeletal

- \_\_\_\_\_ Neck pain
- \_\_\_\_\_ Shoulder pain
- \_\_\_\_\_ Back pain
- \_\_\_\_\_ Hip pain
- \_\_\_\_\_ Knee pain or weakness
- \_\_\_\_\_ Foot/Ankle pain
- \_\_\_\_\_ Hand/Wrist pain
- \_\_\_\_\_ Muscle pain/weakness
- \_\_\_\_\_ Other \_\_\_\_\_

Neuropsychological

- \_\_\_\_\_ Seizures
- \_\_\_\_\_ Numbness
- \_\_\_\_\_ Bad temper
- \_\_\_\_\_ Depression
- \_\_\_\_\_ Anxiety
- \_\_\_\_\_ Poor memory
- \_\_\_\_\_ Loss of balance
- Have you ever been treated for  
emotional problems?
- \_\_\_\_\_ Yes \_\_\_\_\_ No
- \_\_\_\_\_ Other \_\_\_\_\_

Is there anything you wish to bring  
to our attention that is not asked  
on this form?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ACUPUNCTURE AND CHINESE MEDICINE CENTER**

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

**Plum Blossom or Seven Star Hammer:** a light tapping of an area of the body with a small, sterile hammer that has seven points.

**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:**

( \_\_\_\_\_ ) \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# ACUPUNCTURE AND CHINESE MEDICINE CENTER

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## Cancellation and Rescheduling Policy

A 24-hour notice of cancellation made during business hours is required if you need to cancel or reschedule your appointment. 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.

## Payment Policy

Payment is expected at the time of your visit. We accept checks, credit cards 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.

You may submit a claim form with our monthly statement for insurance reimbursement, if you're insurance covers acupuncture and we are not a PPO provider.

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.

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Signature of Patient

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Date