Woodbury Family Chiropractic
Custom Adjustments. Amazing Results

Acupuncture Patient Health History

Name: _____ _____ _____ Today's Date: _____/____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone Number: _____

Occupation:_____

Reason(s) for Visit:

1) Main _____

2) Secondary _____

3) Additional _____

Have you seen a healthcare provider for your main compaint today? What other kinds of care have you received for this?

Do you have any reason to believe you are, or may be, pregnant? _____

If so, how far along are you? _____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

Hospitalizations and Surgeries:

Reason When

_____

_____

X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Exam	Results	When

Emotional (please circle any recurring experience of the following now and underline any that you have experienced in the past):

Mood Swings Nervousness Depression Anxiety PTSD Grief Worry Lack of Motivation Irritability

Other:

Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Tearing/Dryness	Headaches	
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever/Allergy
Blurry/Spotty Vision	Sore Throat at night			

Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema	
Persistent Cough	Asthma	Tuberculosis	Freqeunt Phlegm	
Shortness of Breath				

Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Low Blood Pressure

Chest Discomfort Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

Gastrointestinal (please circle any that you regularly experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Gas Heartburn Bloating Constipation

Loose Stool/ Diarrhea Frequency of Bowel Movement: _____

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Kidney Stones

Impaired Urination Urination Blood in Urine Frequent Urination at Night

Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Light Flow Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods PCOS Ovarian Cysts Low Libido

Menopausal Since Year: _____ Hot Flashes Heat at Night Vaginal Dryness Loss of Libido

Menstrual/Birthing History:

1. Age of First Menses: _____ 4. Birth Control Type: _____

2. # of Days of Menses: _____ 5. # of Live Births: _____

3. Length of Cycle: _____ 6. # of Miscarriages: _____

Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Low Libido Testicular Pain/Swelling Infertility

Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

Other: _____

Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Migraine Headaches describe:_____

Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Excess Sweating Feeling too Hot or Cold

Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Fatigue Catch cold easily

LIFESTYLE

Do you currently follow a special diet, or have any food restrictions?

Do you have any cravings for certain foods or tastes? Y N If so, what do you crave, and when (ie.salty, sweet, carbs, etc?)

Exercise routine:

Stress Reduction/Spiritual practice:

Sleep

How many hours per night do you sleep? _____ Do you wake rested? Y N

Do you wake in the middle of the night? Y N Trouble Falling Asleep? Y N

Do you smoke cigarettes? Y/N

Do you drink alcohol Y/N Frequency _____

FINANCIAL POLICY

PAYMENTS: Payment is due at the time services are rendered, unless other arrangements have been made in advance. We accept cash, check, or VISA/MC/DISCOVER. Returned checks are subject to a $25 service charge. Any account that becomes delinquent will be subject to collections service.

** Beginning March 21st, 2017 Woodbury Family Chiropractic will be implementing a 24-hour cancellation policy for all massage and acupuncture services. A $15.00 fee will be charged to your account if a massage or acupuncture appointment is missed or 24-hour notice is not given. (Extenuating circumstances will be reviewed on a case by case basis at the discretion of Woodbury Family Chiropractic.)

In the event you would like to cancel or reschedule your appointment, please call our office at **612.293.9294**. If your call is outside of regular business hours, please leave a message.

Patient Name _____ Date _____

Patient Signature _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.
I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.
I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.
While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.
I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:	
ACUPUNCTURIST SIGNATURE:	DATE:
PATIENT SIGNATURE:	DATE:

(Or Patient Representative) (Indicate relationship if signing for patient)