Woodbury Family Chiropractic
Custom Adjustments, Amazing Results

Acupuncture Patient Health History

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

Date of Birth: ____/____/_____

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 complaint today? What other kinds of care have you received for this?

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

Do you currently have a pacemaker? Yes No

Do you have any compromised skin (psoriasis, eczema, rashes)? Yes No

Do you have any scars? Yes No

Do you have a history of vertigo/dizziness? Yes No

Do you have a history of migraines? Yes No

Do you have any sensitivities/allergies to oils, lotions, or smells? Yes No

Do you have any reason to believe you are, or may be, pregnant? Yes No

If so, how far along are you? _____

If applicable, please fill out the following section as it pertains to you:

Women's Health (please circle any that you experience now):

Irregular Cycles Breast Lumps/Tenderness Light Flow Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Difficulty Conceiving Painful Periods PCOS Ovarian Cysts Low Libido

Hot Flashes Heat at Night Vaginal Dryness

Menstrual/Birthing History:

1. Age of First Menses: _____
2. # of Days of Menses: _____
3. Length of Cycle: _____
4. Birth Control Type: _____
5. # of Live Births: _____
6. # of Miscarriages: _____

If going through menopause, last period was on: _____

Men's Health (please circle any that you experience now):

Erectile Dysfunction Prostate Problems Low Libido Testicular Pain/Swelling Infertility

Abnormal Sperm Low Sperm Count Blood in Urine/Semen Abdominal Hernia

Constipation/Diarrhea Depression Insomnia Hot Flashes

Please rate the following as 0 = never, 1 = sometimes, 2 = most of the time, and 3 = all the time

Lung Meridian

Discomfort in shoulder, chest, or upper back
0 1 2 3
Concerns with energy levels or skin health
0 1 2 3
Would like respiratory or immune support
0 1 2 3
Feels of grief or sadness
0 1 2 3
Being impulsive or impatient
0 1 2 3

Large Intestine Meridian

Discomfort in low back, hip, or shoulder
0 1 2 3
Concerns with digestive flora and colon
0 1 2 3
Would like digestive or immune support
0 1 2 3
Feeling stuck or blocked
0 1 2 3
Difficulty letting go emotionally
0 1 2 3
Feeling burdened
0 1 2 3

Stomach Meridian

Discomfort in sinuses, esophagus, or neck
0 1 2 3
Concerns with digestion or thyroid
0 1 2 3
Would like digestive or thyroid support
0 1 2 3
Feeling easily overstimulated
0 1 2 3
Feeling spacey or distracted
0 1 2 3
Feeling scattered
0 1 2 3

Spleen Meridian

Discomfort in upper back or left side only
0 1 2 3
Concerns with energy level and muscle tone
0 1 2 3
Would like digestive or endocrine support
0 1 2 3
Feeling overprotective or worried
0 1 2 3
Feeling needy or ignored
0 1 2 3
Feeling emotionally insecure
0 1 2 3

Heart Meridian

Discomfort in jaw, left shoulder, or sacrum
0 1 2 3
Concerns with sleep cycle and heart function
0 1 2 3
Would like heart or hormone support
0 1 2 3
Feelings of melancholy or general sadness
0 1 2 3
Feelings of self-doubt
0 1 2 3
Easily feeling arrogant or self-absorbed
0 1 2 3

Small Intestine

Discomfort in knees, jaw, or abdomen
0 1 2 3
Concerns with digestion or absorption
0 1 2 3
Would like digestive or immune support
0 1 2 3
Feeling self-critical
0 1 2 3
Feeling narrow-minded
0 1 2 3
Being obsessed with details
0 1 2 3

Urinary Bladder Meridian

Discomfort of entire back, head, or ankle
0 1 2 3

Concerns with stress hormones and nerves
0 1 2 3

Would like muscular-skeletal support
0 1 2 3

Feeling indecisive or self-sabotaging
0 1 2 3

Feeling emotionally ambivalent
0 1 2 3

Physically or emotionally inflexible
0 1 2 3

Kidney Meridian

Discomfort in low back and inner thigh
0 1 2 3

Concerns with hormones and detoxing
0 1 2 3

Would like endocrine or skeletal support
0 1 2 3

Feeling self-destructive
0 1 2 3

Feeling betrayed or holding grudges
0 1 2 3

Feeling over-controlling
0 1 2 3

Pericardium Meridian

Discomfort in rib cage or posterior hip
0 1 2 3

Concerns with metabolism and hormones
0 1 2 3

Would like endocrine and digestive support
0 1 2 3

Feeling fanatical and over-zealous
0 1 2 3

Feeling manic at times
0 1 2 3

Having lack of direction
0 1 2 3

Triple Burner Meridian

Discomfort in joints in general or hairline
0 1 2 3

Concerns with fluid retention or metabolism
0 1 2 3

Would like lymph or immune support
0 1 2 3

Feeling emotionally repressed
0 1 2 3

Feelings of rigidity and tied to expectations
0 1 2 3

Feeling overly bound to rules
0 1 2 3

Gallbladder Meridian

Discomfort in tendons, shoulders, or temples
0 1 2 3

Concerns with muscles or digestion
0 1 2 3

Would like respiratory or immune support
0 1 2 3

Feeling emotionally detached or aloof
0 1 2 3

Feeling misunderstood or fearing change
0 1 2 3

Feeling or acting rebellious
0 1 2 3

Liver Meridian

Discomfort in chest, abdomen, or shoulders
0 1 2 3

Concerns with detoxing and hormones
0 1 2 3

Would like digestive and detox support
0 1 2 3

Feelings of anger or frustration
0 1 2 3

Feeling caught in addiction or illusions
0 1 2 3

Feeling overly sensitive
0 1 2 3

SAFETY PRECAUTION

Acupuncture is a specialized technique in which an acupuncturist or certified practitioner inserts needles into the muscles at specific points. The needles used are very thin - about 0.2mm in diameter, and can be easily missed when they are being taken out. Our practitioners will make every effort to remove all needles before you leave the treatment room. Please help your acupuncturist by doing a body scan and checking for any remaining needles. If you happen to find one, please notify our staff right away. Thanks for your help!

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.

Patient Name_____ Acupuncturist Name_____

Patient Signature_____ Acupuncturist Signature_____

Today's Date_____ Today's Date_____

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