RIVERVIEW HEALTH
Exceptional People. Exceptional Care.

ACUPUNCTURE

Second Floor Clinic
323 S Minnesota Street
Crookston, MN 56716
218-281-9519

East Grand Forks Clinic
1428 Central Avenue NE
East Grand Forks, MN 56721
218-773-1390

Thief River Falls Clinic
1140 Vanrooy Drive
Thief River Falls, MN 56701
218-416-5770

PATIENT INFORMATION

Today's Date: _____Name: _____ Date of Birth: _____

Address: _____ Occupation: _____

Primary Phone: _____H/W/C (Please circle) Secondary Phone: _____H/W/C

Emergency Contact: _____ Phone: _____

Marital Status: □ Single □ Married □ Living with Significant Other □ Separated □ Divorced □ Widowed

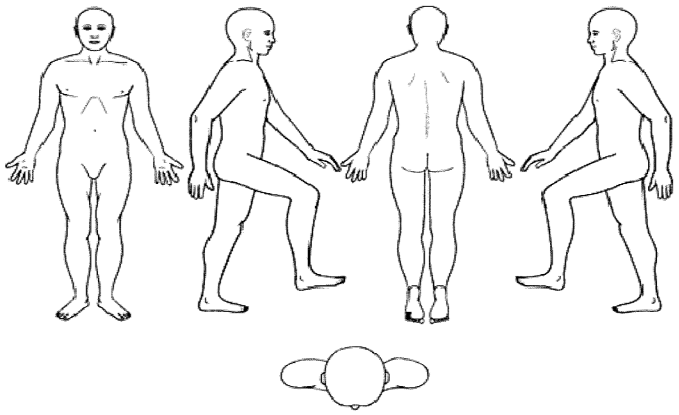
What is your primary reason for coming in for treatment? When did this start? How does it affect your life? Please describe: _____

_____

LOCATE YOUR PAIN

On the drawing at the right, please mark any areas where you experience pain (p) or numbness (n).

Rate the pain for each location from 0-10.



Have you been examined by a medical doctor or other healthcare provider for these concerns? □ yes □ no

If so, diagnoses: _____

Current Physician: _____

Last Medical Exam: _____

Have you ever received acupuncture? □ yes □ no

When and for what?_____

SYMPTOMS YOU EXPERIENCE REGULARLY

Please check *symptoms you experience regularly.*

TEMPERATURE
- □ Tend to feel hot
- □ Tend to feel cold
- □ Hot flashes
- □ Chills
- □ Fever
- □ Alternating chills and fever
- □ Cold hands/feet
- □ Night sweats
- □ Sweat with no exertion
- □ No sweat

HEAD
- □ Headaches
- □ Migraines
- □ Dizzy/lightheaded
- □ Fainting
- □ Foggy-headedness
- □ Sinus congestion
- □ Nasal discharge

LUNGS & HEART
- □ Wheezing
- □ Coughing
- □ Short of breath
- □ Tight sensation in chest
- □ Frequent colds, >2/year
- □ Seasonal allergies
- □ Palpitations/fluttering sensation
- □ Chest pain

BOWEL MOVEMENTS
- □ Constipation
- □ Loose stool/diarrhea
- □ Alternating constipation and diarrhea
- □ Cramps with BM
- □ Incomplete BM
- □ Burning with BM
- □ Hemorrhoids
- □ Bowel incontinence
- □ Blood or mucus in stool
- □ Foul odor

PERSPIRATION/MOUTH THIRST
- □ Thirsty
  - □ Drink cold □ Drink hot
- □ No thirst
- □ Sore throat
- □ Dental problems
- □ Taste in mouth _____

SENSES
- □ Declining vision
- □ Red/itchy eyes
- □ Floating spots in vision
- □ Poor hearing
- □ Ear ringing

APPETITE & DIGESTION
- □ Heartburn/reflux
- □ Nausea/vomiting
- □ Gas
- □ Tired after eating
- □ Bad breath
- □ Bloating/distention
- □ Abdominal pain
- □ Belching/hiccups
- □ Pain under ribs

URINATION
- □ Dark urine
- □ Cloudy urine
- □ Burning urination
- □ Scanty urine
- □ Profuse urine
- □ Decreased bladder control
- □ Frequent urination
- □ Wake at night twice or more to urinate
- □ Frequent UTIs

ENERGY
- □ Low
- □ Normal
- □ High

SKIN, HAIR & NAILS
- □ Dry skin/nails
- □ Easily bruised
- □ Acne
- □ Hair loss

CRAVINGS
- □ Sweet
- □ Salty
- □ Sour
- □ Bitter
- □ Hot/spicy
- □ Strong flavor/pungent
- □ Bland

SLEEP
- □ Insomnia
- □ Excessive sleep
- □ Difficulty falling asleep
- □ Wake during the night
- □ Vivid/disturbing dreams
- □ Wake unrefreshed

MENTAL & EMOTIONAL
- □ Forgetful/poor memory
- □ Poor concentration
- □ Irritable/angry
- □ Sad
- □ Tearful/weepy
- □ Restless
- □ Anxious/worried
- □ Can't stop obsessive thinking
- □ Fearful/easily startled
- □ Depressed
- □ Frequent sighing or yawning

MEDICAL HISTORY

Please check if you have been diagnosed with any of these conditions:

□ AIDS/HIV
□ Alcoholism
□ Allergies/Hay Fever
□ Anemia
□ Arthritis
□ Asthma
□ Cancer
□ Cardiovascular Disease: High blood pressure, high cholesterol, heart disease, heart attack, stroke (circle those that apply)
□ Depression/Anxiety/Mental Illness
□ Diabetes
□ Fibromyalgia
□ GERD
□ Headaches, Migraines (circle those that apply)
□ Hepatitis
□ Infertility
□ Irritable Bowel Syndrome
□ Kidney Disease
□ Liver Disease
□ Multiple Sclerosis
□ Seizures
□ Thyroid Condition
□ Tuberculosis
□ Ulcers

□ Other (please describe) _____

List serious accidents, traumas, hospitalizations, surgeries, or illnesses: _____

_____

_____

FAMILY HISTORY

Check if there is family history of the following conditions **(please write which relative underneath the condition)**:

□ Diabetes □ High blood pressure □ Heart disease □ Cancer □ Allergies □ Mental illness

□ Other: _____

Medications and supplements:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

List allergies: _____

Is there anything else you would like me to know? _____

_____

_____

WOMEN'S HEALTH HISTORY

MENSTRATION

Age when menses began: _____

Last menstrual period start date: _____ Menstruation lasts _____ days

Regular/Irregular Periods (circle one) _____ days between periods

Menstrual flow is light/moderate/ heavy and pink/red/purple/brown/other _____

Do you experience:

□ Clots in menstrual flow
□ Cramps
□ Breast tenderness
□ Food cravings
□ Sadness or weeping
□ Dizziness
□ Insomnia
□ Other _____
□ Spotting between periods
□ Back pain
□ Bowel changes
□ Irritability or anger
□ Acne
□ Fatigue
□ Night sweats

How many pregnancies _____ live births _____ abortions _____ miscarriages _____ have you had?

MENOPAUSE

Are you currently menopausal? Y/N/?

In what year was your last period? _____

Do you currently experience any:

□ Night sweats
□ Vaginal dryness
□ Hot flashes (daytime)
□ Spotting

□ Other _____