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

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

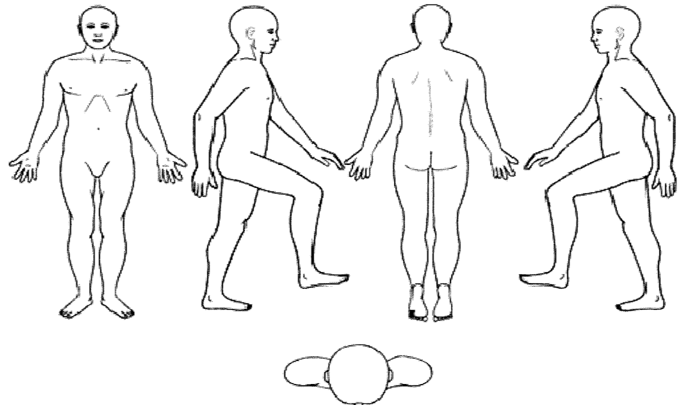
What is your primary reason for coming in for treatment? When did this start? How does it affect your life? Please describe: ____

____

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
- □ Hot flashes (daytime)
- □ Vaginal dryness
- □ Spotting

□ Other ____