Advanced Acupuncture & Pain Management Clinic, LLC
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Clinic: 612 – 547 – 9301 Cell: 763 – 213 – 9936

DATE:____/____/_____

PATIENT INFORMATION:

Name: _____

Age: _____ Date of Birth: ____/____/_____ Gender: _____

Home Address: _____ Phone: **(**_____**)**_____-_____

_____ Email: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone number: **(**_____**)**_____-_____

Primary Care Physician: _____ Phone: **(**_____**)**_____-_____

Date of last medical examination: ____/____/_____

EXPERIENCE WITH ACUPUNCTURE

Have you received acupuncture treatment before? YES NO

If yes, for what conditions and what was the outcome?

Are there any health conditions the practitioner should be aware about prior to treatment such as diabetes, low blood pressure, ETC?

_____

_____

_____

_____

COMPLAINTS:

What are your main complaints?

Primary Complaint: _____

_____

_____

_____

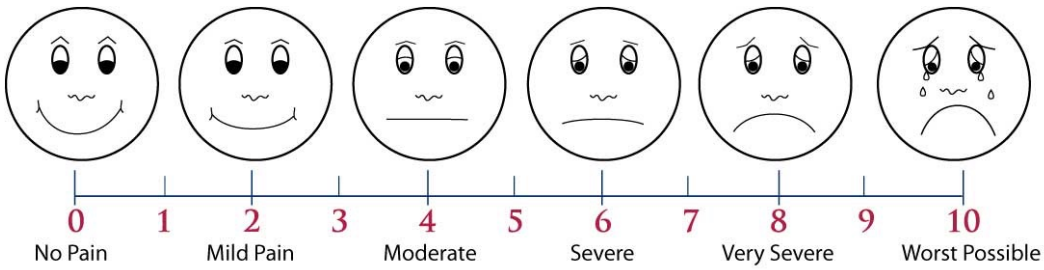
_____

_____

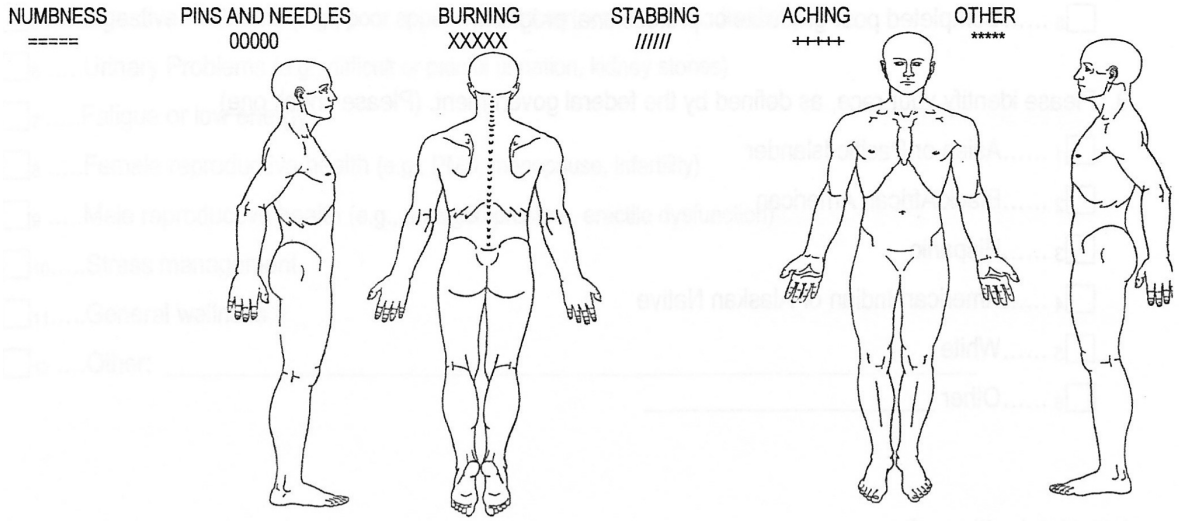
_____

_____

Please indicate on the scale below where you would rate your PRIMAIRY complaint.



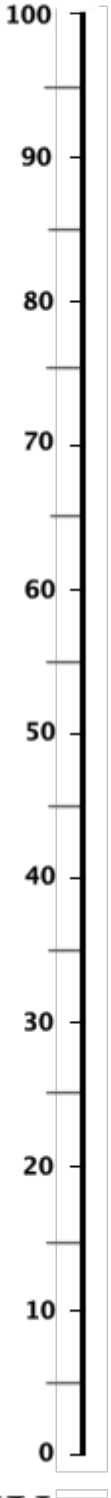
On the diagram, please indicate the areas where you feel symptoms associated with your complaints.



Please mark on the scale below where you would rate your current overall quality of life.

Quality of Life Scale

Best



Worst

PRIMARY COMPLAINT:

Please answer all of the following questions focusing on your Primary Complaint ONLY:

1. Briefly explain history of your Primary Complaint, i.e. how long have you had this condition; was the onset SUDDEN or GRADUAL; was there a significant event that lead to this condition?

2. Have you seen a physician (or other primary care provider) for your Primary Complaint? If yes, when and what diagnosis did you receive?

3. Other Care: what other therapies are you doing or have you done to manage your Primary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did any of these therapies help?

PERSONAL MEDICAL HISTORY:

COMORBIDITIES	PRE-EXISTING MEDICAL CONDITIONS (Circle all that apply/write in other)
1. Neurological	- Epilepsy, MS, Parkinson's, Other: _____
2. Mental Health	- Depression, Anxiety, Other: _____
3. Head, Ears, ENT	- Headaches, Chronic Sinusitis, Other: _____
4. Respiratory/Pulmonary	- Asthma, Emphysema, Other: _____
5. Cardiovascular	- CVA, CHF, Hypertension, Other: _____
6. Gastrointestinal	- GERD, IBS, Ulcers, Gastritis, Other: _____
7. Genitourinary	- UTI, Other: _____
8. Women's Health/Gynecology	- PMS, Infertility, Other: _____
9. Men's Health	- BPH, ED, Other: _____
10. Immunologic and Allergic	- Lupus, HEP, HIV/AIDS, Other: _____
11. Musculoskeletal	- Lumbago, Carpal Tunnel, OA, RA, Other: _____
12. Endocrine and Metabolic	- Hyper/Hypo Thyroid, Diabetes, Other: _____
13. Other	- Dermatologic, Infectious, Other: _____

FAMILY MEDICAL HISTORY:

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER: _____

FATHER: _____

SIBLINGS: _____

MATERNAL GRANDPARENTS: _____

PATERNAL GRANDPARENTS: _____

MEDICATIONS, SUPPLEMENTS AND HERBS:

Please list all medications, (prescriptions and over-the-counter drugs) supplements and or herbs you are CURRENTLY taking:

Medications, supplements, or herbs:	*Indication/For treatment of:*
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

LIST ANY ALLERGIES (to medications, supplements, herbs):