

Blackstone Acupuncture, LLC

blackstoneacu@gmail.com

612.747.6489

3249 Hennepin Avenue Suite 227
Minneapolis, Minnesota 55408

2913 Harriet Ave. S. Suite 103
Minneapolis, Minnesota 55408

DATE: _____

PATIENT INFORMATION:

Name: _____ Gender: _____

Age: _____ Date of Birth: _____

Home Address: _____

Phone: _____ Email: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Date of last medical examination: _____

Do I have permission to contact your PCP regarding your treatment? Yes No

EXPERIENCE WITH ACUPUNCTURE

Have you received acupuncture treatment before? YES NO

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

What are your main complaints?

Primary Complaint: _____

Secondary Complaint: _____

PRIMARY COMPLAINT:

Please answer 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/ have you done to manage your Primary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/are these other therapies helping?

SECONDARY COMPLAINT:

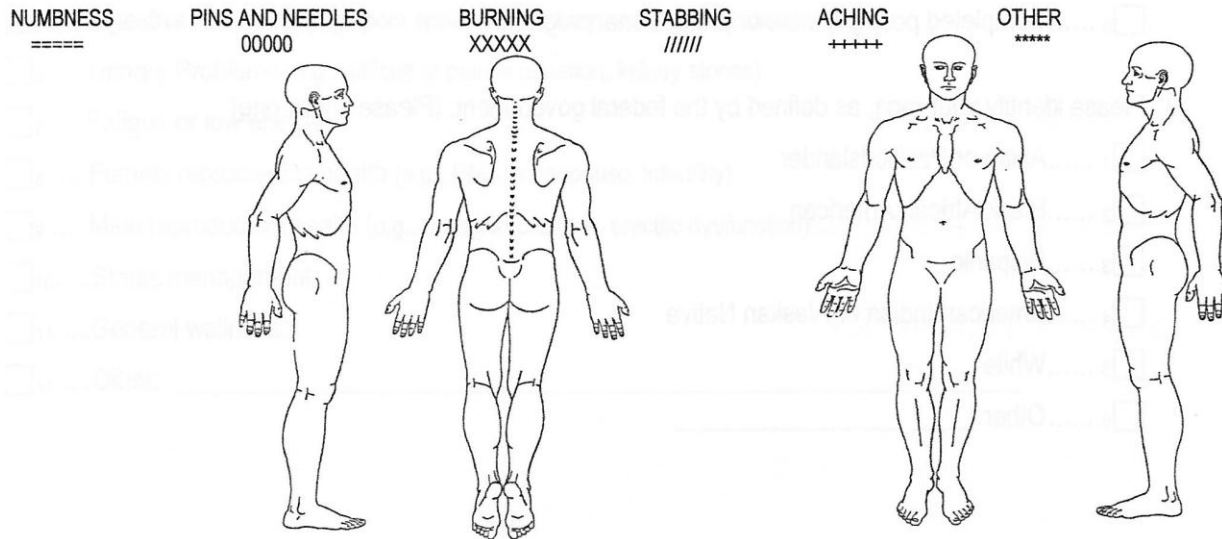
Please answer the following questions focusing on your Secondary Complaint ONLY:

1. Briefly explain history of your Secondary 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 Secondary Complaint? If yes, when and what diagnosis did you receive?

3. Other Care: what other therapies are you doing/ have you done to manage your Secondary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?

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



MEDICATIONS, SUPPLEMENTS AND HERBS:

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

<i>Medications, supplements, or herbs:</i>	<i>Indication/For treatment of:</i>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

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

PERSONAL MEDICAL HISTORY:

BIRTH: Describe anything significant/traumatic about your birth:

VACCINATION HISTORY: Any unusual reaction? Any unusual vaccination?

CHILDHOOD ILLNESSES (0-12 years): Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____

AGE: _____

ADOLESCENCE ILLNESSES (13-17 years): Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____

AGE: _____

ADULTHOOD ILLNESSES (18-35 years): Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____

AGE: _____

ADULTHOOD ILLNESSES (36 and up): Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____

AGE: _____

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: _____

SYMPTOM OVERVIEW BY SYSTEM:

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY. Please indicate (by circling) if the symptom is acute, chronic or experienced frequently.

A = Acute (under 3 months)

C = Chronic (over 3 months experience at some point most days)

F = Experience frequently (on and off)

MUSCULOSKELETAL

- A C F Joint clicking
- A C F Limitation of movement
- A C F Stiffness
- A C F Spasms or cramps
- A C F Swelling
- A C F Weakness
- A C F Pain: Full body
- A C F Pain: Facial (e.g. jaw)
- A C F Pain: Neck
- A C F Pain: Upper Back
- A C F Pain: Mid Back
- A C F Pain: Low Back
- A C F Pain: Shoulder
- A C F Pain: Elbow
- A C F Pain: Wrist
- A C F Pain: Hand
- A C F Pain: Hip
- A C F Pain: Knee
- A C F Pain: Ankle
- A C F Pain: Foot
- A C F OTHER (Please list)

EYES, EARS, NOSE and THROAT

- A C F Loss of vision
- A C F Eye pain
- A C F Tearing or eye dryness
- A C F Eye discharge
- A C F Eye redness
- A C F Ear discharge
- A C F Ear itching
- A C F Ear pain and/or infections
- A C F Loss of hearing
- A C F Ringing or buzzing in ears
- A C F Problems with balance (vertigo)
- A C F Olfaction (sense of smell) impaired
- A C F Nose obstruction (stiffness)
- A C F Nose bleeds
- A C F Sinus pain, pressure and/or infections
- A C F OTHER (Please list)

RESPIRATORY

- A C F Chest pain and/or tightness
- A C F Bluish discoloration of skin
- A C F Cough
- A C F Coughing up blood (hemoptysis)
- A C F Shortness of breath (dyspnea)
- A C F Sore throat
- A C F Sputum production
- A C F Voice changes
- A C F Wheezing
- A C F OTHER (Please list)

CARDIOVASCULAR

- A C F Changes in skin temperature
- A C F Chest pain and/or pressure
- A C F Edema
- A C F Fainting (syncope)
- A C F Fatigue
- A C F Palpitations
- A C F Skin ulceration
- A C F Swelling of ankles and/or legs
- A C F OTHER (Please list)

DIGESTIVE

- A C F Abdominal distention
- A C F Abdominal mass
- A C F Abdominal pain
- A C F Acid regurgitation and/or Heartburn
- A C F Alternating constipation/diarrhea
- A C F Rectal bleeding
- A C F Constipation
- A C F Diarrhea
- A C F Gas
- A C F Eating disorder
- A C F Indigestion
- A C F Jaundice (yellow tint to skin and/or eyes)
- A C F Nausea
- A C F Vomiting
- A C F OTHER (Please list)

UROGENITAL

- A C F Difficulty with urine flow
- A C F Incontinence
- A C F Painful urination (dysurea)

- A C F Rashes
- A C F Red urine
- A C F Urinary tract infection (UTI)
- A C F OTHER (Please list)

NEUROLOGICAL

- A C F Changes in consciousness
- A C F Confusion
- A C F Difficulty concentrating
- A C F Dizziness
- A C F Dysphasia (impaired ability to speak)
- A C F Gait disturbance
- A C F Headache
- A C F Numbness and/or tingling
- A C F Loss of consciousness
- A C F Paralysis
- A C F Post shingles pain
- A C F Problems coordinating movements
- A C F Severe forgetfulness
- A C F Tremor
- A C F Visual disturbance
- A C F Weakness
- A C F OTHER (Please list)

INTEGUMENTARY (SKIN)

- A C F Changes in hair
- A C F Changes in nails
- A C F Changes in skin color
- A C F Itching (prurites)
- A C F Never sweat
- A C F Rash and/or skin lesion
- A C F Unusual sweating
- A C F Wounds that will NOT heal
- A C F OTHER (Please list)

PSYCHOLOGICAL

- A C F Feelings of grief
- A C F Feeling of sadness
- A C F Feeling fearful/anxious/nervous
- A C F Difficulty managing anger
- A C F Feeling manic
- A C F Feeling worried or overly pensive
- A C F Feelings of panic
- A C F Feeling overwhelmed
- A C F Extreme mood swings
- A C F Extreme lack of emotion
- A C F OTHER (Please list)

SLEEP

- A C F Difficulty falling asleep
- A C F Dream disturbed sleep
- A C F Wake up and cannot fall back asleep
- A C F OTHER (Please list)

MISCELLANEOUS

- A C F Extremely low energy/fatigue
- A C F OTHER (Please list)

FOR WOMEN ONLY

- A C F Abnormal vaginal bleeding
- A C F Changes in hair distribution
- A C F Fertility concerns
- A C F Irregular menstruation
- A C F Menopausal symptoms
- A C F No menses
- A C F Pain with menses (dysmenorrhea)
- A C F Pain during or after sexual relations
- A C F Pelvic pain
- A C F Premenstrual symptoms
- A C F Sexual dysfunction
- A C F Unusual discharge
- A C F OTHER (Please list)

Are you pregnant OR trying to become pregnant? Y N

Have you ever been pregnant? Y N

If yes, how many pregnancies:

Births: _____

Miscarriages: _____

Abortions: _____

Periods:

Age of 1st period: _____

Date of most recent period: _____

of days it lasts: _____

Have you ever had an abnormal pap result? Y N

If yes, please describe:

FOR MEN ONLY

- A C F Fertility concerns
- A C F Prostate problems
- A C F Sexual dysfunction
- A C F Unusual discharge
- A C F OTHER (Please list)

MEDICAL DISEASES/CONDITIONS:

Please check all that apply AND indicate (by circling) if it is chronic or if you had the problem in the past, but is now resolved.

C = Current condition

P = Past condition, but is now resolved.

C P AIDS/HIV
 C P Alcoholism and/or substance addiction
 C P Allergies
(If yes, pls indicate diagnosis and history)

C P Anemia
 C P Asthma
 C P Bell.s Palsy
 C P Blood clotting disorder
(If yes, pls indicate diagnosis and history)

C P Bipolar disorder
 C P Cancer (If yes, pls give history)

C P Chron.s Disease and/or colitis
 C P Chronic Fatigue Syndrome (CFIDS)
 C P Depression (Major)
 C P Diabetes
 C P Eczema
 C P Endometriosis
 C P Fibroids
 C P Infertility
 C P Lung disease, e.g. COPD
(If yes, pls indicate diagnosis and history)

C P Fibromyalgia
 C P Gallstones
 C P Heart disease
(If yes, pls indicate diagnosis and history)

C P Hepatitis A / B / C
 C P Hernia
 C P Herpes
 C P Hypertension
 C P Hypoglycemia
 C P Irritable Bowel Syndrome (IBS)
 C P Joint Replacement
(If yes, pls indicate diagnosis and history)

C P Kidney Stones and/or Disease
(If yes, pls indicate diagnosis and history)

C P Lupus
 C P Lyme Disease
 C P Lymph node removal

C P Mitral valve prolapse
 C P Mood Disorder

C P Mononucleosis
 C P Multiple Sclerosis
 C P Organ removal or transplant
(If yes, pls indicate diagnosis and history)

C P Osteoarthritis
 C P Osteoporosis
 C P Pacemaker (heart or stomach)
 C P Parkinson.s Disease
 C P Pelvic Inflammatory Disease
 C P Polio
 C P Psoriasis
 C P PTSD (Post-Traumatic Stress Disorder)
 C P Reflux esophagistis (GERD)
 C P Rheumatic fever
 C P Rheumatoid arthritis
 C P Scarlet Fever
 C P Schizophrenia
 C P Scoliosis
 C P Seizures and /or epilepsy
 C P Shingles
 C P Sleep Disorder
 C P Stroke
 C P Schizophrenia
 C P Thyroid disease
(If yes, pls indicate diagnosis and history)

C P Ulcer
 C P Trigeminal Neuralgia
 C P Tuberculosis
 C P Vascular disease (e.g. phlebitis)
(If yes, pls indicate diagnosis and history)

C P OTHER (pls list)

LIFESTYLE INFORMATION:

Stress, Energy Level and Sleep

What aspects of your life do you enjoy?

What aspects of your life are stressful to you?

Do you think that stress, including any recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, briefly describe:

Do you have any problems with your energy level? If yes, please briefly describe:

Do you have any problems with sleep? If yes, please briefly describe:

Do you have any problems with your sexual drive? If yes, please briefly describe:

What do you do for stress reduction?

Diet and Nutrition

Please describe what you typically eat throughout the day:

Breakfast (time of day ____):

Lunch (time of day ____):

Dinner (time of day ____):

Snacks (times of day ____):

What beverages do you drink?

How much water do you drink a day?

Do you experience food cravings? If yes, please describe:

Do you wish to make any changes in what you eat? If yes, please describe:

Do you wish to make any changes in what you drink? If yes, please describe:

Do you believe that your diet has any impact on your complaints? YES NO

Please indicate usage per day or per week.

Please circle if the usage was in the past

Cigarettes: _____ Per _____ In the past

Alcohol: _____ Per _____ In the past

Recreational Drugs: _____ Per _____ In the past

Tea: _____ Per _____ In the past

Soft Drinks: _____ Per _____ In the past

Sugar: _____ Per _____ In the past

Coffee: _____ Per _____ In the past

Chocolate: _____ Per _____ In the past

Other: _____ Per _____ In the past

EXERCISE

Do you get regular exercise? If yes, please describe:

Do you spend time outdoors?

What are your goals, hopes and expectation for your acupuncture treatments?