Northwoods Acupuncture & Wellness Center

(612) 600-5761

New Patient Health Assessment Form

Please take tie to thoughtfully and honestly answer these questions. Some may seem unrelated to your condition; however, they may play a major role in the diagnosis and treatment. The holistic view of Traditional Chinese Medicine looks at the body as a whole, rather than individual symptoms, to get to the root of the problem. All information provided is held strictly confidential. This form will not be released to a third party without your consent.

Today's Date | Last Name | First Name | Middle Initial

SS#:

Address:

City:

State: Minnesota | Zip Code:

Birth Date | Weight

Age | Height | Sex

Home Phone

Work Phone

Cell Phone

Which number is best to leave a message?

Email Address

Would you like to be on my email list to receive my newsletter and specials?

Marital Status

- ☐ Single
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Married/Living with Significant Other

Spouse's Name | Age | Occupation

How many children do you have?

Person to Notify in Case of Emergency

Relationship

Name

Phone

How did you hear about Northwoods Acupuncture and Wellness Center?

Have you ever received acupuncture before?

What is the reason you have decided to try acupuncture & oriental medicine?

Concern (rank by priority)	Date of Onset	Initial Cause	Frequency	Severity
Example: Headache	*July, 1978*	*Head-on Collision*	*4 times/week*	*Mild/Moderate/Severe*

Have you been examined by a medical doctor for any of these health concerns?

If yes, what were the diagnoses?

For the main health issue that you would like to focus on today:

How long have you had this condition?

What seemed to be the initial cause?

Does it affect your: (check all the apply) ☐ Sleep ☐ Work ☐ Other

If other, please explain

Please explain how these conditions affect or impair your daily activities:

Describe your symptoms when they are at their worst:

What seems to make it better?

What seems to make it worse?

Have you tried other therapies for this?

If so, what?

HEALTH HISTORY

Family Medical History

(Grandparents, Parents, Siblings, Children)

- ☐ Alcoholism
- ☐ Asthma/Hay Fever/Hives
- ☐ Borderline Personality Disorder
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Scizophrenia
- ☐ Suicide
- ☐ Mental Illness
- ☐ Others

Your Medical History

Significant trauma (accidents, falls, etc...)

1. Date
2. Date

X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

1. Date Results
2. Date Results

OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation	Where	Physician

MEDICATIONS *List all prescriptions and over-the-counter drugs that you are currently taking*

Medication	Dose & Frequency	Begin Date	Reason

VITAMINS / SUPPLEMENTS *List all you are currently taking*

Vitamin/Supplement	Dose & Frequency	Begin Date	Reason

ALLERGIES

Drug or Substance	When do they occur?	Reaction

Have you ever been diagnosed with Cancer? What type: Date

Have you ever been diagnosed with Hepatitis? What type: Date

Have you ever been diagnosed with HIV/AIDS? Which: Date

OVERVIEW OF SYSTEMS

Respiratory:

- ☐ Coughing
- ☐ Wheezing
- ☐ Shortness of Breath/Difficulty Breathing
- ☐ Tight sensation in chest
- ☐ Frequent Colds - more than 2/year
- ☐ Excessive coughing up of Phlegm
- ☐ Emphysema
- ☐ Pleurisy
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Allergies
- ☐ Other Respiratory Problems (list below)

Cardiovascular:

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure

Last Reading: When?

- ☐ Chest Pain
- ☐ Palpitations / Fluttering Sensation
- ☐ Swelling of Ankles
- ☐ Stroke
- ☐ Heart Attack
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Anemia
- ☐ High Cholesterol
- ☐ Other Cardiovascular Problems (list below)

Energy and Immunity:

- ☐ Fatigue
- ☐ Excessive Energy
- ☐ Slow Wound Healing
- ☐ Chronic Infections
- ☐ Chronic Fatigue Syndrome
- ☐ Other E/I Problems (list below)

Perspiration/Thirst:

- ☐ Spontaneous Sweating
- ☐ Night Sweats
- ☐ Thirsty for warm beverages
- ☐ Thirsty for cold beverages
- ☐ Dry mouth but no desire to drink
- ☐ Other P/T Problems (list below)

Psychiatric / Emotional:

- ☐ Cannot shut mind off
- ☐ Poor Concentration
- ☐ Forgetful / Poor Memory
- ☐ Irritability / Anger
- ☐ Sadness / Depression
- ☐ Frequent Crying
- ☐ Fearful
- ☐ Frequent sighing or yawning
- ☐ Mood Swings
- ☐ Other Psych/Em Problems (list below)

Eyes:

- ☐ Impaired Vision
- ☐ Eye Pain / Strain
- ☐ Glasses / Contacts
- ☐ Floaters
- ☐ Tearing / Dryness
- ☐ Red/ Itchy eyes
- ☐ Eye sensitivity to light
- ☐ Poor night vision
- ☐ Dark circles under eyes
- ☐ Other Eye Problems (list below)

Head, Ear, Nose:

- [ ] Impaired Hearing
- [ ] Ear Ringing
- [ ] Earaches
- [ ] Headaches
- [ ] Migranes
- [ ] Sinus Problems
- [ ] Nose Bleeds
- [ ] Other H/E/N problems (list below)

Hair, Skin & Nails:

- [ ] Dry, brittle hair
- [ ] Hair Loss
- [ ] Premature gray hair
- [ ] Acne
- [ ] Eczema / Hives
- [ ] Rashes
- [ ] Dry, Brittle nails
- [ ] Other Hair/Skin/Nail problems (list below)

Musculoskeletal:

- [ ] Neck/Shoulder Pain
- [ ] Muscle Spasms/Cramps
- [ ] Arm Pain
- [ ] Back Pain or weakness

If so, where?

- [ ] Leg Pain
- [ ] Knee Pain or weakness
- [ ] Joint Pain

If so, where?

- [ ] All over body heaviness or pain
- [ ] Muscle Tightness
- [ ] Other problems in this area (list below)

Throat & Mouth:

- [ ] Frequent Sore Throats
- [ ] Dry mouth & throat
- [ ] Feeling of Lump in Throat
- [ ] Swollen / Painful Gums
- [ ] Teeth Grinding
- [ ] Sensitive Teeth
- [ ] TMJ / Jaw Problems
- [ ] Mouth / Canker Sores
- [ ] Lip Sores
- [ ] Taste in mouth — If so, what taste:
- [ ] Other Throat/Mouth problems (list below)

Gastrointestinal:

- [ ] Low Appetite
- [ ] Excessive Appetite
- [ ] Cravings: Sweet, salty, sour, bitter, salty, spicy — Which?
- [ ] Tired after eating
- [ ] Nausea / Vomiting
- [ ] Bad Breath
- [ ] Bloating / Distention
- [ ] Passing Gas
- [ ] Heartburn / Acid Reflux
- [ ] Belching / Hiccups
- [ ] Abdominal Pain
- [ ] Pain under ribs or ribside
- [ ] Gallstones
- [ ] Gall Bladder Disease
- [ ] Liver Disease
- [ ] Hepatitis B or C
- [ ] Ulcers

If so, where:

- [ ] Ulcerative Colitis
- [ ] Other problems in this area (list below)

Neurological:

- [ ] Vertigo / Dizziness
- [ ] Paralysis Numbness / Tingling
- [ ] Loss of Balance
- [ ] Seizures / Epilepsy
- [ ] Tremors
- [ ] Restless Leg Syndrome
- [ ] Other Neuro Problems (list below)

Bowels:

- [ ] Constipation
- [ ] Loose stool / Diarrhea
- [ ] Alternating Constipation and Diarrhea
- [ ] Hemorroids
- [ ] Pain with bowel movement
- [ ] Bowel incontinence
- [ ] Blood or mucus in stool
- [ ] Foul Odor
- [ ] Other Bowel Problems (list below)

Endocrine:

- [ ] Hypothyroid
- [ ] Hyperthyroid
- [ ] Hypoglycemia
- [ ] Diabetes [ ] Type 1 [ ] Type 2
- [ ] Night Sweats
- [ ] Specific Hormonal Imbalance
- [ ] Other Endocrine Problems (list below)

Temperature:

- [ ] Tend to feel hot
- [ ] Tend to feel cold
- [ ] Cold hands and feet
- [ ] Alternating chills & fever
- [ ] Other Temperature Problems (list below)

Genito-Urninary:

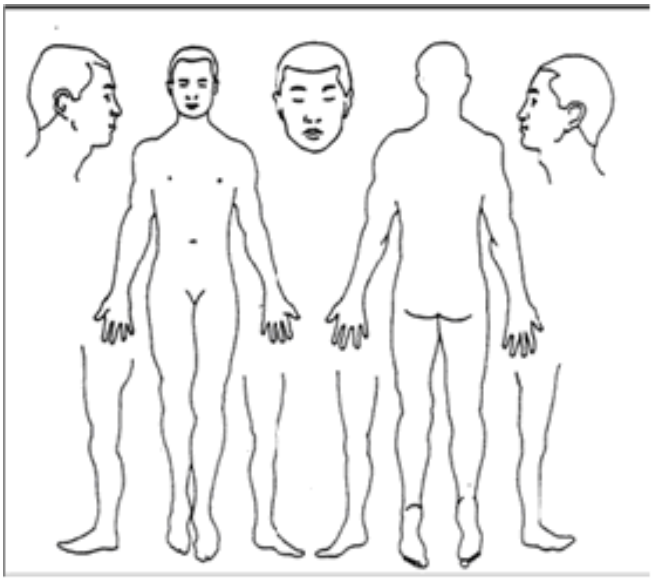
- [ ] Kidney Disease
- [ ] Kidney Stones
- [ ] Painful / Burning Urinations
- [ ] Cloudy Urine
- [ ] Dark Urine
- [ ] Frequent Urination
- [ ] Frequent UTI's
- [ ] Blood in Urine
- [ ] Impaired Urination
- [ ] Heavy Flow
- [ ] Scanty Flow
- [ ] Decreased bladder control
- [ ] Frequent Urination in evening
- [ ] Wake at night to urinate
- [ ] Other Reproductive Problems (list below)

Male Reproductive:

- [ ] Sexual Difficulties
- [ ] Prostrate Problems
- [ ] Testicular Pain / Swelling
- [ ] Penile Discharge
- [ ] Premature Ejaculation
- [ ] Infertility
- [ ] Other Reproductive Problems (list below)

Please mark the following codes where you feel pain or discomfort:
XXX = sharp pain or stabbing pain; PPP = Pins & Needles; DDD = Dull/Aching; NNN = Numbness

******If completing this form online, the therapist will ask you to complete this diagram on your initial visit.**



LIFESTYLE

How often do you typically consume alcoholic drinks (e.g. beer, wine, etc.)? If every day, how many/day?

How often do you typically consume caffeinated drinks (e.g. coffee, soda)? If every day, how many/day?

How many glasses of non-caffeinated, non-carbonated beverages (water, juice do you drink per day?

Do you use tobacco products (e.g. cigarettes, chewing tobacco, pipe)?

If, yes but in the past, please indicate year quit:

Do you use any recreational drugs? If yes, what?

Do you typically eat 3 meals per day? If no, how many?

Your typical diet (please be specific):

Breakfast	Lunch	Dinner	Snacks

On average, how much physical activity, exercise, or sports activities have you taken part in during the past month?

What do you do to relax?

How many hours per night do you sleep?

Do you participate in any spiritual practices?

Do you fall asleep easily?

Wake in the middle of the night?

If yes, what?

Vivid Dreams?

Disturbing Dreams?

Wake Rested?

Occupation

Employer

Hours/Week

Do you enjoy your work?

Why / Why not?

Interests and hobbies:

Is there anything else that you would like me to look into with you?

I hereby give consent for treatment by Amy Kaiser, L.Ac..
I accept full financial responsibility for all medical services performed on my behalf.

Signed _____ **Date**_____

Parent/Guardian _____ **Date**_____

Once complete, save to your desktop and email as an attachment to: ***amy@northwoodsacu.com***